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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01821

CERTIFICATE OF DEATH

Reg. Dist. No. 01804

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elliotts			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital, Inc.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Abbott				4. DATE OF DEATH Month Day Year February 9 19 62			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1962	
9. AGE (In years lost birthday) yrs. Months Days Hours Min. 4		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Theodore Abbott				14. MOTHER'S MAIDEN NAME Georgene Martinek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Jean Martinek		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematurity 1 lb 4 3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 hrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-9, 1962 , to 2-9, 1962 , that I last saw the deceased alive on 2-9, 1962 , and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Jean Martinek				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/62		22c. NAME OF CEMETERY OR CREMATORY Martinek Cemetery		22d. LOCATION (City, town, or county) (State) Elliott, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Jean Martinek				ADDRESS Elliott, Md		24a. REC'D BY REGISTRAR DATE FEB 21 '62	
						24b. REGISTRAR'S SIGNATURE Arthur S. House	

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01822

CERTIFICATE OF DEATH

Reg. Dist. No. 03135

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) 16 Moores Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Sharp Last Brown				4. DATE OF DEATH Month February Day 27 Year 1962			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1891	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dor-Co-Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph H. Roberts		14. MOTHER'S MAIDEN NAME Priscilla Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-7274		17. INFORMANT Mr. Charlie Brown-Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1962 , to Feb 27, 1962 , that I last saw the deceased alive on February 27, 1962 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 2-28-62 ACTUAL SIGNATURE J. Edwin Fassett, M.D. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/62		22c. NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		22d. LOCATION (City, town, or county) (State) Cortown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert W. S. S. S. ADDRESS High St., Cambridge, Md.				24a. REC'D BY REGISTRAR MAR 22 '62		24b. REGISTRAR'S SIGNATURE Clifford S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(M)

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		COUNTY _____	
DATE OF DEATH _____		PLACE OF DEATH _____		COUNTY _____	
TIME OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____		SIGNATURE OF REGISTRAR _____	
CERTIFICATE NO. _____		COUNTY _____		STATE _____	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the Registrar of the State Department of Health, who will issue a certificate of death to the family of the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01823 CERTIFICATE OF DEATH 01805

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Doc</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>					
c. LENGTH OF STAY IN TB <u>Four Days</u>				d. STREET ADDRESS <u>Somerset Ave</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary Louise Cheesman</u>				4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/11/1887</u>			
9. AGE (In years, months, days) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Home</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Franklin Clark</u>				14. MOTHER'S M maiden NAME <u>Annie Vickers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u> </u>					
17. INFORMANT <u>Otto Cheesman</u>				Address <u>313 Somerset Ave Cambridge Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>444X</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u>								INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis</u> <u>Aneurysm Aorta</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>024X</u>					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Hanks</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/19/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>				22d. ADDRESS <u>Cambridge Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/18/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town or county) (State) <u>East New Market MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kilgus</u>				ADDRESS <u>East New Market</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 23 '62</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kilgus</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled out by the funeral director. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01824

CERTIFICATE OF DEATH

01806

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN b <u>Nine Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GOILT</u> d. STREET ADDRESS <u>14X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Middle</u> <u>Last</u> <u>Ruben Francis Cole</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1876</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>#### Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Cole</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hummel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records Cambridge Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>general Arteriosclerosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26, 1962</u> to <u>Feb 4, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 3, 1962</u> and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas J. Dredge</u> M.D.		22b. DATE SIGNED <u>2-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>		22d. ADDRESS <u>Cambridge Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 6, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Townsend Cem</u>		23d. LOCATION (City, town or county) (State) <u>Townsend Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>G. Lester Daniels</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 7 '62</u>	
ADDRESS <u>Middletown, Delaware</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

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John A. Lippard

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01825

01807

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge Md. Hospital		c. LENGTH OF STAY IN lb 1 Day		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md. RFD#3		d. STREET ADDRESS Cambridge RFD#3 Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Middleton		First T.		Middle Cook		Last Cook		4. DATE OF DEATH Feb. 14, 1962		Month Feb.		Day 14,		Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1880		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY W Md. R.R.				11. BIRTHPLACE (County & State, or foreign country) Dorchester Co.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Alfred Cook						14. MOTHER'S MAIDEN NAME Catherine Spedden											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Calvin Cook				Address Cambridge RFD#3 Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 446X DUE TO Arterio sclerotic nephritis generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)												INTERVAL BETWEEN ONSET AND DEATH 7 days. 2 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1/29/62 to 2/13/62 , that (I) (we) last saw the deceased alive on 2/13/62 , and that death occurred 2/13/62 from the causes and on the date stated above.																	
22a. SIGNATURE Lawrence Maryanov						M.D. Lawrence Maryanov				22b. DATE SIGNED 2/15/62							
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov						22d. ADDRESS Cambridge, Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 16, 1962				23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park				23d. LOCATION (City, town or county) (State) Cambridge, Maryland.					
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service						ADDRESS Cambridge, Md.				25a. REC'D BY REGISTRAR DATE FEB 20 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01826

01808

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
c. LENGTH OF STAY IN 1b <u>1 yr 8 mos</u>		d. STREET ADDRESS <u>114 S. 1st St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital, Cambridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Christopher</u> Middle <u>C</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-71</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Ezekiel Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Louise Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Medical Records</u>		Address <u>ESSA, Cambridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 30, 1960</u> to <u>FEB. 20, 1962</u> that (I) (we) last saw the deceased alive on <u>FEB. 18, 1962</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. Longley</u>		22b. DATE SIGNED <u>2/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>		22d. ADDRESS <u>EASTERN SHORE STATE HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam</u>		25. REC'D BY REGISTRAR <u>FEB 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

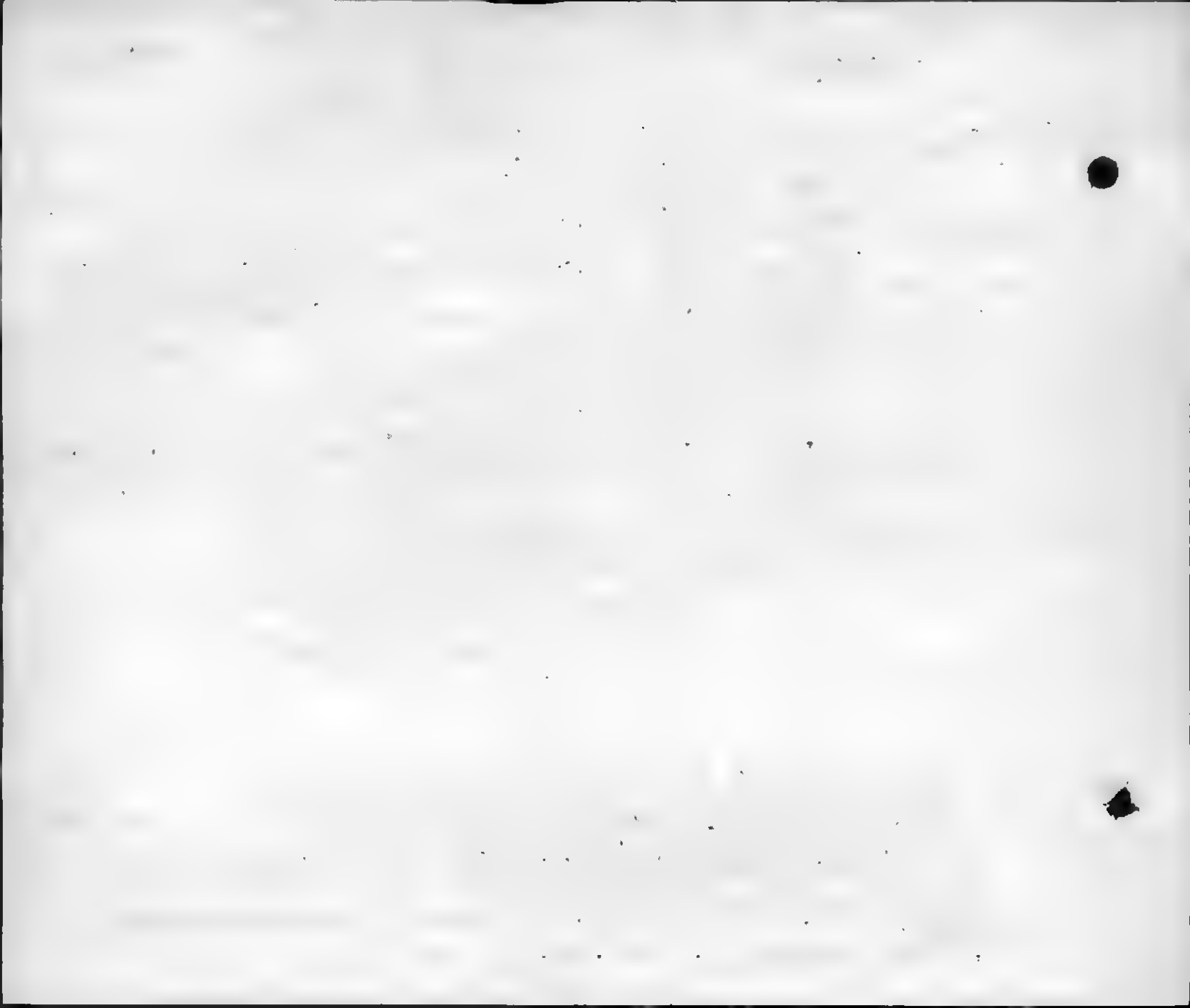
CERTIFICATE OF DEATH

01827

01809

12
M
16
I
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN <u>16 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) <u>Ellen E. Emmait</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, '83</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. Weatherstine</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Seebode</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Hospital Records Cambridge Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cancer of Intestine</u> (c) <u>Interval BETWEEN ONSET AND DEATH</u> <u>unk</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5, 1962</u> to <u>Feb 21, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 20, 1962</u>, and that death occurred at <u>11:58 PM</u>, from the causes and on the date stated above							
22a. SIGNATURE <u>Thomas J. Dredge</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2-21-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>		22d. ADDRESS <u>Cambridge Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 24, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION (City, town or county) <u>Baltimore</u>	(State) <u>Maryland</u>	25a. REC'D BY REGISTRAR <u>DATE FEB 26 '62</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Sander & Sons, Inc. Balto., Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to the Medical Examiner's Office.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01828

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01810

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

25 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge-Maryland Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Lester

Alan

Goslin

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

March 21, 1911

9. AGE (In years
last birthday)

50 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Can Mfrg., employee

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Linkwood, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Herbert J. Goslin

14. MOTHER'S MAIDEN NAME

Della Bassett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

214-07-8491

17. INFORMANT

Thomas H. Goslin, Cambridge, Md., R.D. 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Heart disease

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work ☐ Not While
at work ☐

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

2/3/62

Address (Street, city, town, or county)

Cambridge, Md.

(State)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

Feb. 4, 1962

Dorchester Memorial Park Cambridge, Md.

23. FUNERAL DIRECTOR

ADDRESS

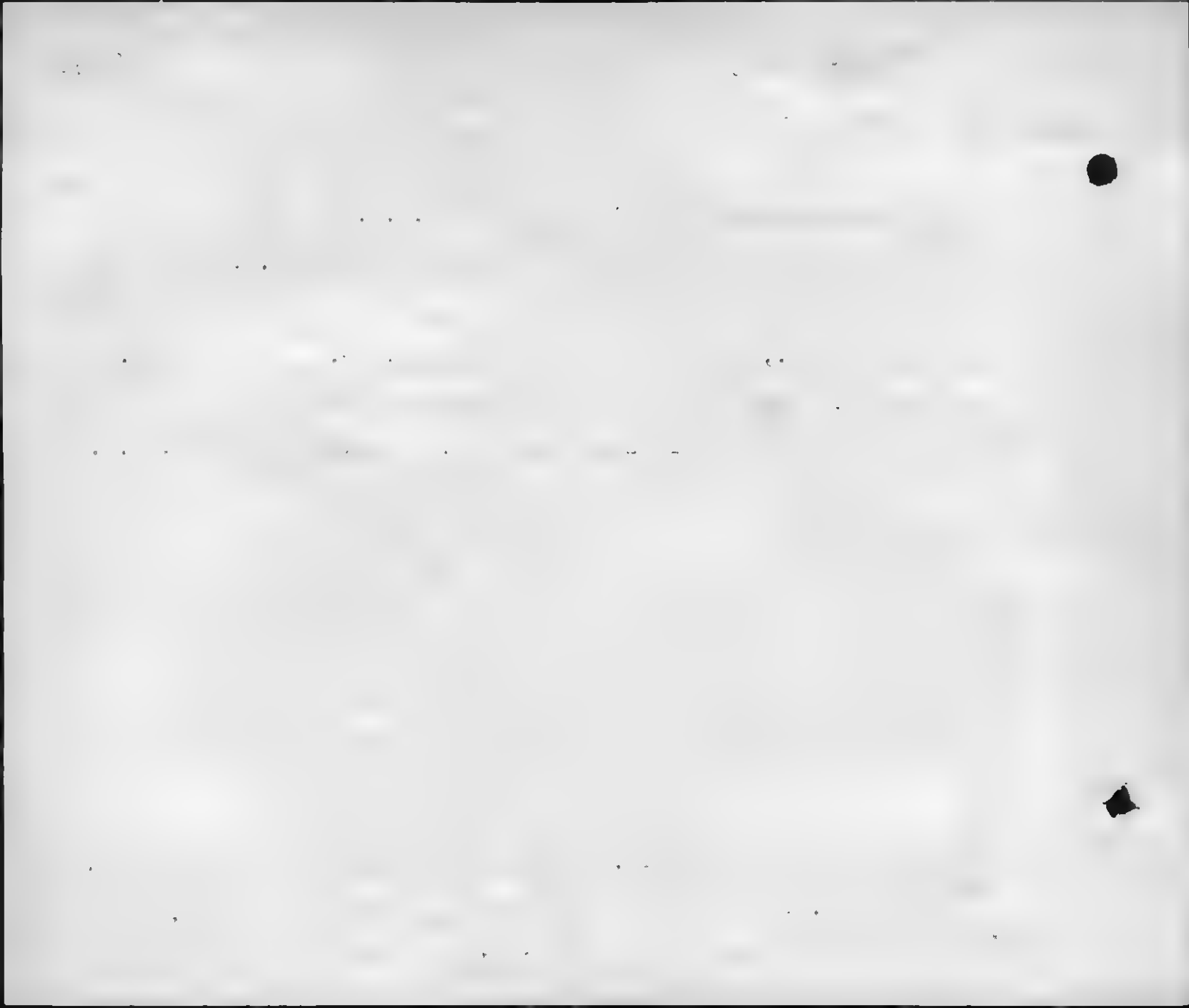
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Kenneth R. Thomas, Cambridge, Md.

DATE FEB 7 '62

Signature



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

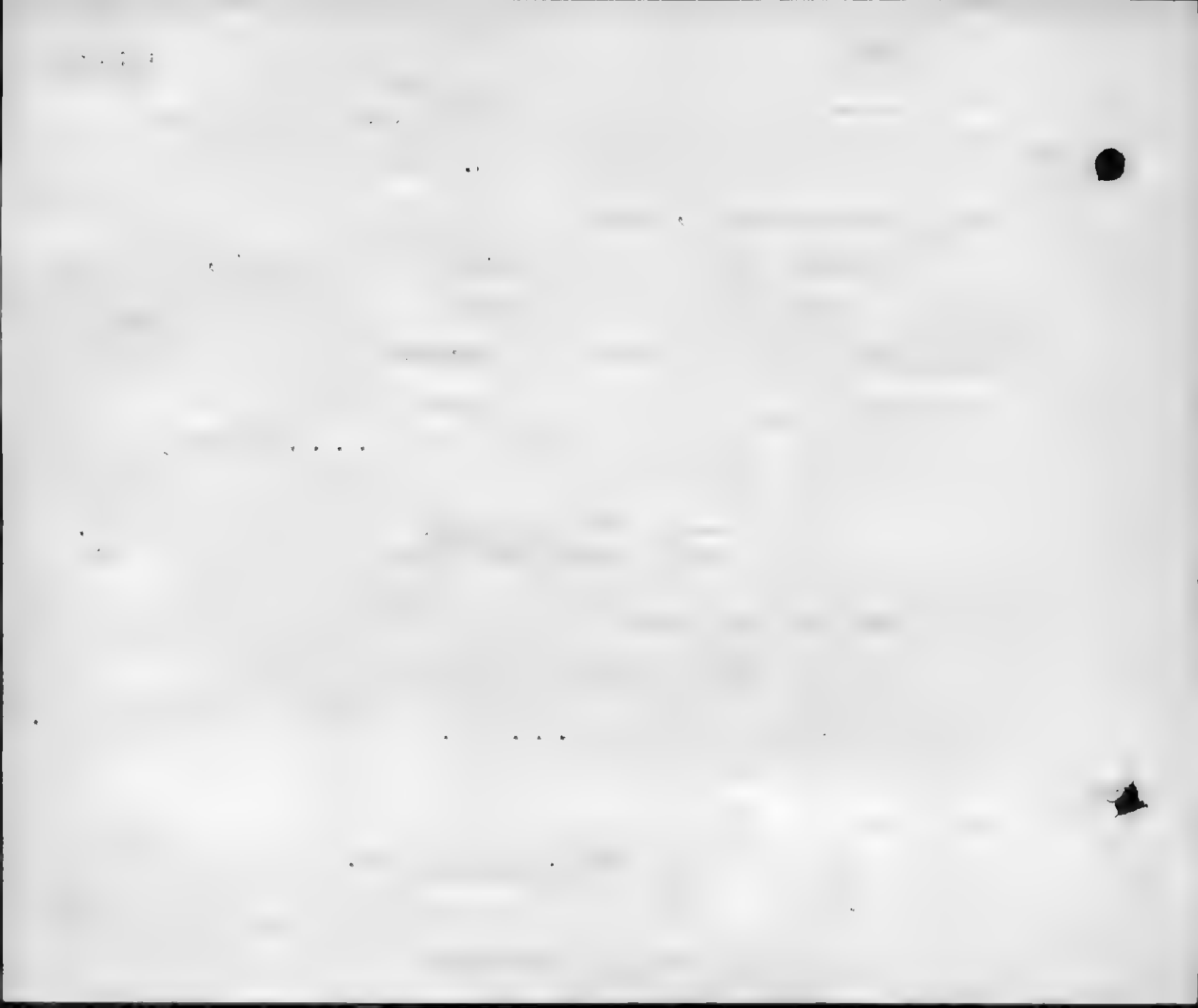
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01829

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01811

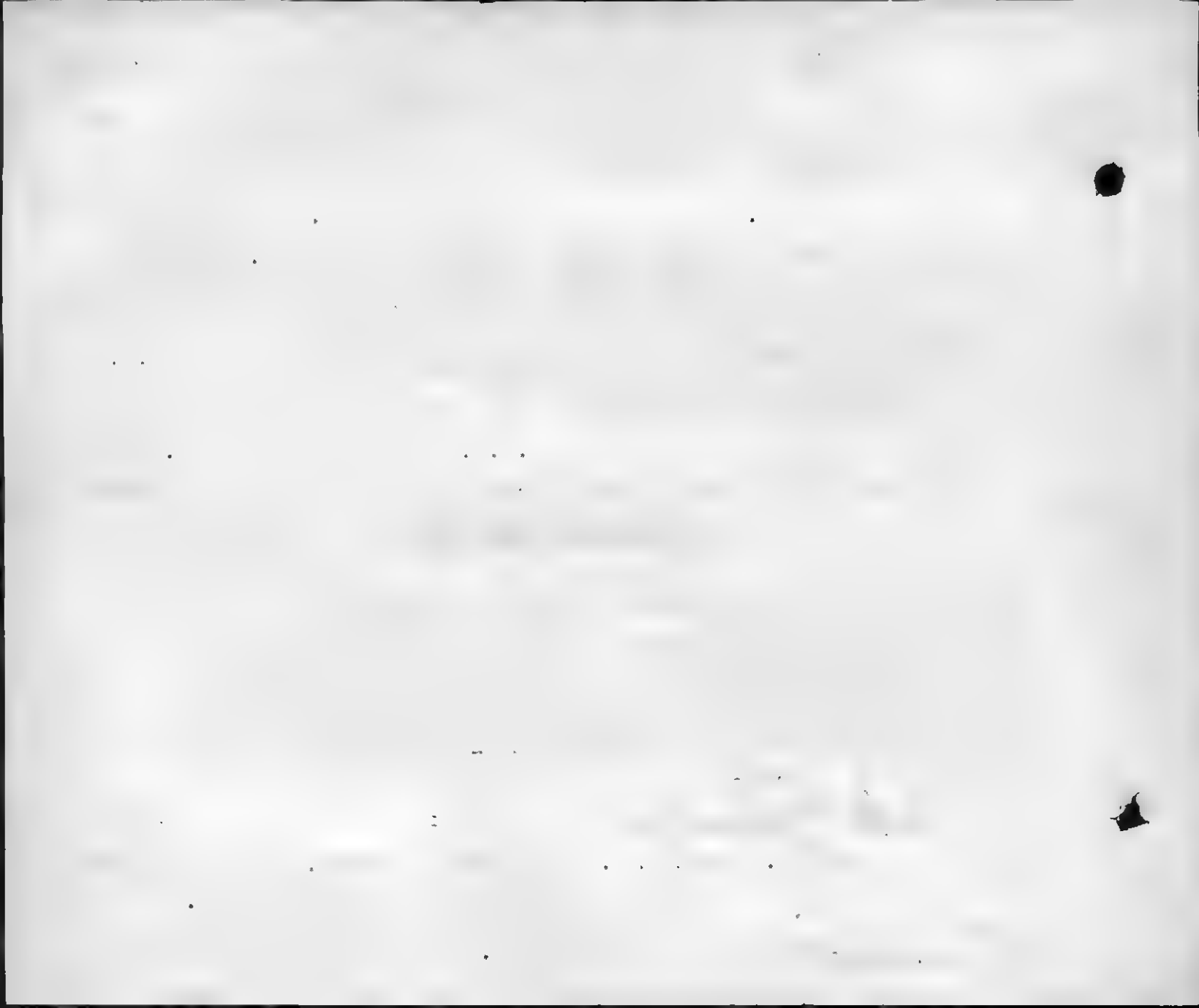
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge c. LENGTH OF STAY IN 1b 1 yr 8 mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital, Cambridge				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels d. STREET ADDRESS 218 2			
3. NAME OF DECEASED (Type or print) Angie Laramore Harrison		4. DATE OF DEATH Month Feb Day 24 Year 1962		5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/08/82		9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shirt factory		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Laramore		14. MOTHER'S MAIDEN NAME Minerva Shockley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of left leg DUE TO (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease		19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. Intertrochanteric fracture of left hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) fell while standing in line					
20c. TIME OF INJURY Month Day Year 5 8-15-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) E.S.S. Hosp.		20f. (City or town) (County) (State) Cambridge Dorchester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Alfred R. Maryanov		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Alfred Maryanov, 136 Race St., Cambridge, Md.		DATE SIGNED 2/24/62		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/27/62	
22c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) ST. MICHAELS MD.		24a. REC'D BY REGISTRAR FEB 27 '62		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01830					01812				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Dorchester</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				
c. LENGTH OF STAY IN 1b <u>25 years</u>					d. STREET ADDRESS <u>827 Race St.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>827 Race St.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Joseph Whitefield Hastings</u>					4. DATE OF DEATH <u>Feb. 23, 1962</u>				
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>January 11, 1882</u>				
9. AGE (In years last birthday) <u>80</u> yrs					10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Hotel Operator</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County U.S.</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>William Leonard Hastings</u>				
14. MOTHER'S MAIDEN NAME <u>Margaret Ann Hearn</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Mrs. J.W. Hastings, 827 Race St., Cambridge</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									
420.0 DUE TO (b) <u>Arteriosclerotic Heart Disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-24-46</u> to <u>2-23-62</u> , 19....., that (I) (we) last saw the deceased alive on <u>2-23-62</u> , 19....., and that death occurred at <u>1:45 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Albert E. Bunker</u> M.D.					22b. DATE SIGNED <u>2-23-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>ALBERT E. BUNKER, M. D.</u>					22d. ADDRESS <u>200 Maryland Ave., Cambridge, Maryland</u>				
23a. BURIAL, CREMATION, REMOVA- (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Feb. 25, '62</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Shower</u>					25a. REC'D BY REGISTRAR <u>FEB 28 '62</u>				
ADDRESS <u>Cambridge, Md.</u>					25b. REGISTRAR'S SIGNATURE <u>Kenneth R. Shower</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

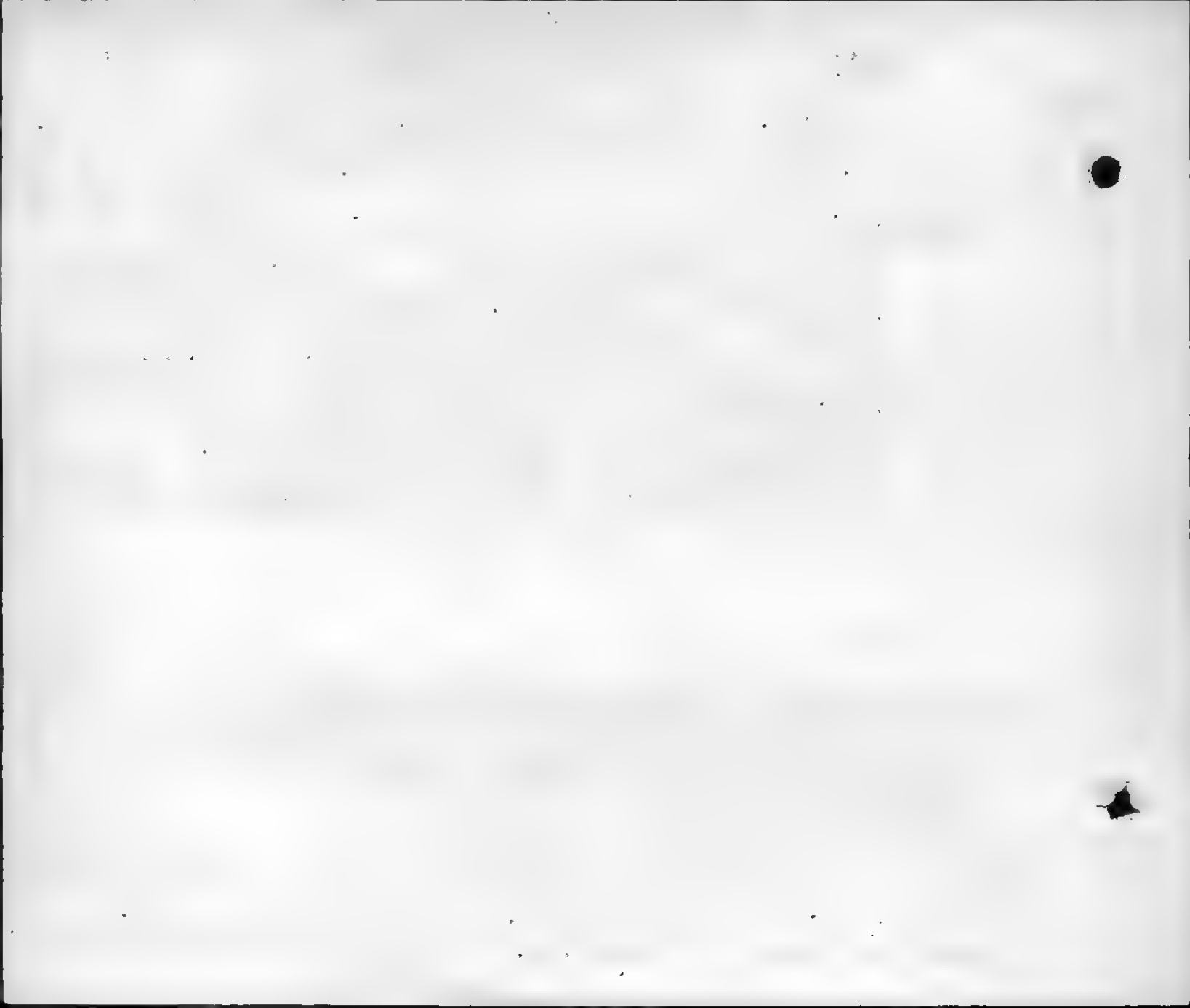
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01831

01813

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>		c. LENGTH OF STAY IN 1b <u>2 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews, Md.</u>		d. STREET ADDRESS <u>Andrews, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>McMaughlin</u> Last <u>Hughes</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>10,</u> Year <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1900</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (County & State or foreign country) <u>Crocheron, Md..</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shriver A. McMaughlin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Todd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Herman Hughes</u>		Address <u>Andrews, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Left</u> Conditions, if any, which gave rise to immediate cause (b) <u>31X</u> (c), stating the underlying cause last. <u>31X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Verbal infection</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> 1962 to <u>2/10</u> 1962 and that death occurred at <u>P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Hanks M.D.</u>				22b. DATE SIGNED <u>2/12/62</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. Hanks M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 12, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01832

CERTIFICATE OF DEATH

03153

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Day		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		d. STREET ADDRESS R.F.D.# 3,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen W. Illing		4. DATE OF DEATH 22 19 62		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/1882		9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months Days 22 19 62		11. IF UNDER 24 HRS. Hours Min. 20 hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin W. Lynch		14. MOTHER'S MAIDEN NAME Mary Wdmsley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Le Comte Funeral Service, Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Perforated ulcer peptic DUE TO (c) Arteriosclerotic cardio vascular renal disease - Diabetes Mellitus		19. INTERVAL BETWEEN ONSET AND DEATH 20 hrs		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from 10-11-61 , 19... to 2-21-62 , 19... that (I) (the) last saw the deceased alive on 2-21-62 , 19... and that death occurred at 10:30 PM , from the causes and on the date stated above.		22a. SIGNATURE Eldridge H. Wolff, M.D.		22b. DATE SIGNED 2-22-62		22c. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.		22d. ADDRESS 15 Locust St., Cambridge, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/ /1962		23c. NAME OF CEMETERY OR CREMATORY Rawayton Union Cemetery		23d. LOCATION (City, town or county) (State) Rawayton, Conn.		24. FUNERAL DIRECTOR'S SIGNATURE Le Comte Funeral Service, Cambridge, Md.		24b. ADDRESS Le Comte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR MAR 12 '62		25b. REGISTRAR'S SIGNATURE Charles S. Hines		25c. DATE MAR 12 '62	



01833

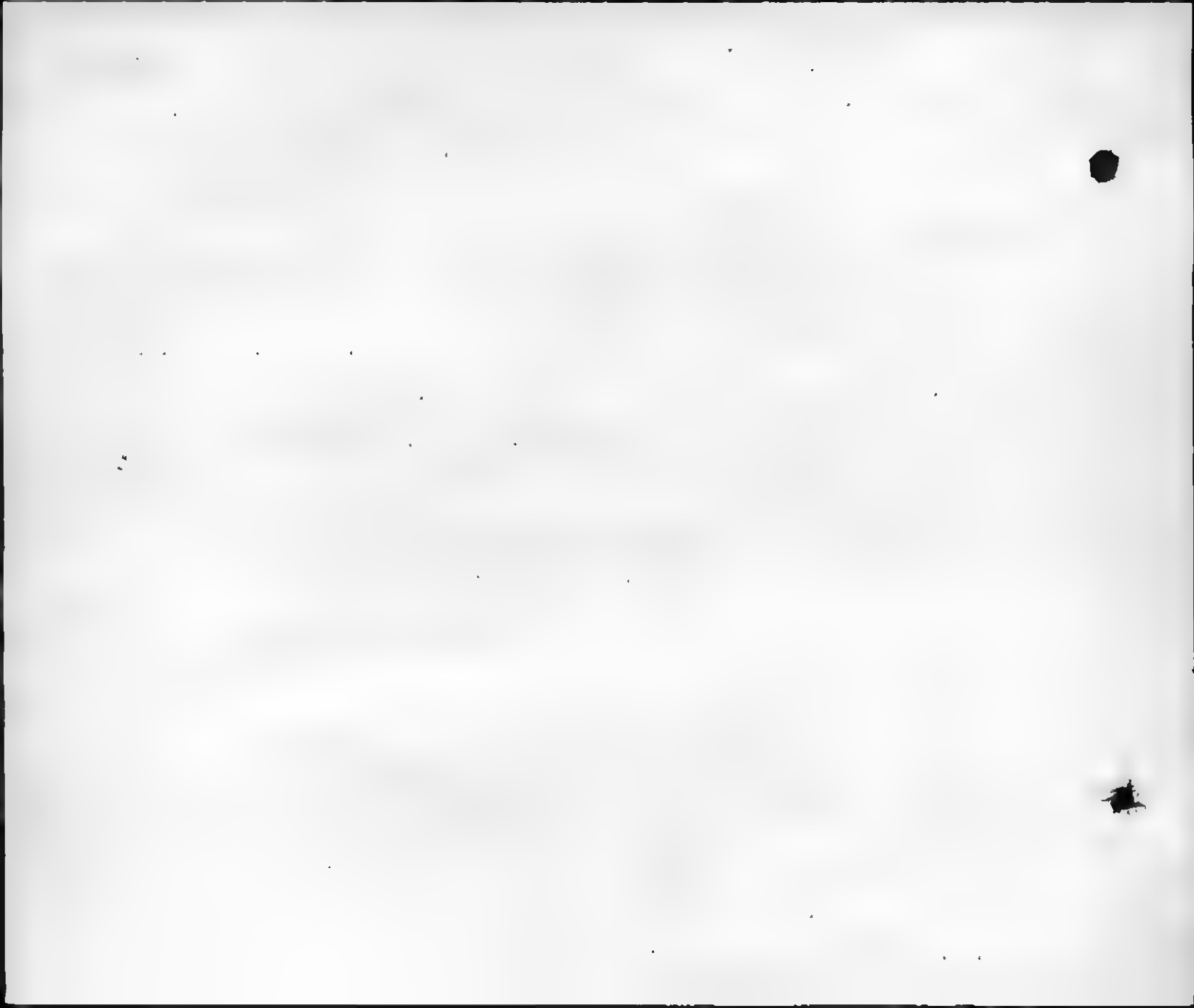
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01814

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Hurlock				c. LENGTH OF STAY IN lb 14 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Front Street				e. STREET ADDRESS Front Street			
3. NAME OF DECEASED (Type or print) First Charles Middle Russell Last Jacobs				4. DATE OF DEATH Month February Day 21 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1920	9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night watchman - American Stores Cannery				10b. KIND OF BUSINESS OR INDUSTRY Preston, Md., R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. Frederick Jacobs				14. MOTHER'S MAIDEN NAME Annie L. Kemp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 218-09-0299		17. INFORMANT Address Mrs. Annie L. Jacobs, Hurlock, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 754.5 DUE TO Chronic Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Congenital Calcified Aortic Stenosis							INTERVAL BETWEEN ONSET AND DEATH minutes 4 yrs Life
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No other significant conditions							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---			
20c. TIME OF INJURY Month 19 Day 19 Year 19 Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-31-1958 to 2-21-1962 that (I) (we) last saw the deceased alive on 2-20-1962 and that death occurred at 4:45 PM from the causes and on the date stated above							
22a. SIGNATURE J. J. Frampton				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 2/21/62	
22c. PHYSICIAN'S NAME (Type) DR. H. B. PLUMMER				22d. ADDRESS Preston Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		23d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE FEB 27 '62		25b. REGISTRAR'S SIGNATURE C. S. S.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No. 01815

01834

1. PLACE OF DEATH a. COUNTY <u>NORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u> 17X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE Hospital</u>		d. STREET ADDRESS <u>HARBOR VIEW DRIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES FRANK KARASEK</u>		4. DATE OF DEATH Month Day Year <u>February 12 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>MEX. WAR</u>		16. SOCIAL SECURITY NO. <u>185-247184</u>	
17. INFORMANT <u>Medical Records of E.S.S.H.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>ATHEROSCLEROTIC C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 YEARS</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROBABLE BRONCHOGENIC CA, LEFT LUNG</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12, 1962</u> to <u>2/12, 1962</u> , that I last saw the deceased alive on <u>2/12, 1962</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Geo M. Dunn</u> M.D.		ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSP. CAMBRIDGE, MARYLAND</u>	
DATE SIGNED <u>2-12-62</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE M. DUNN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/15/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Love</u> ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Wm. S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY
Dorchester
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cambridge
c. LENGTH OF STAY IN
2yr. 11mos. 3das.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Eastern Shore State Hospital

1. PLACE OF DEATH

a. COUNTY

Dorchester

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN

2yr. 11mos. 3das.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eastern Shore State Hospital

3. NAME OF DECEASED
(Type or print)

First

Charles

Middle

King

Last

Keithley

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

04-02-83

4. DATE OF DEATH

February 27 19 62

9. AGE (In years last birthday)

78

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired factory worker

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Keithley

14. MOTHER'S MAIDEN NAME

Susan Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-12-5620

17. INFORMANT

Eastern Shore State Hospital records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

491X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

BRONCHOPNEUMONIA

INTERVAL BETWEEN ONSET AND DEATH

3 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

DEHYDRATION, ATRIAL FIBRILLATION, ARTERIOSCLEROSIS

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from 3-24 1959 to 2-27, 1962 that (we) last saw the deceased alive on 2-27 1962 and that death occurred 11:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

George M. Dunn

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED

2-27-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/2/62

23c. NAME OF CEMETERY OR CREMATORY

Elkton Cemetery

23d. LOCATION (City, town or county)

Elkton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Ralph E. Hicks, Elkton, Md.

25a. REC'D BY REGISTRAR

DATE MAR 14 '62

25b. REGISTRAR'S SIGNATURE

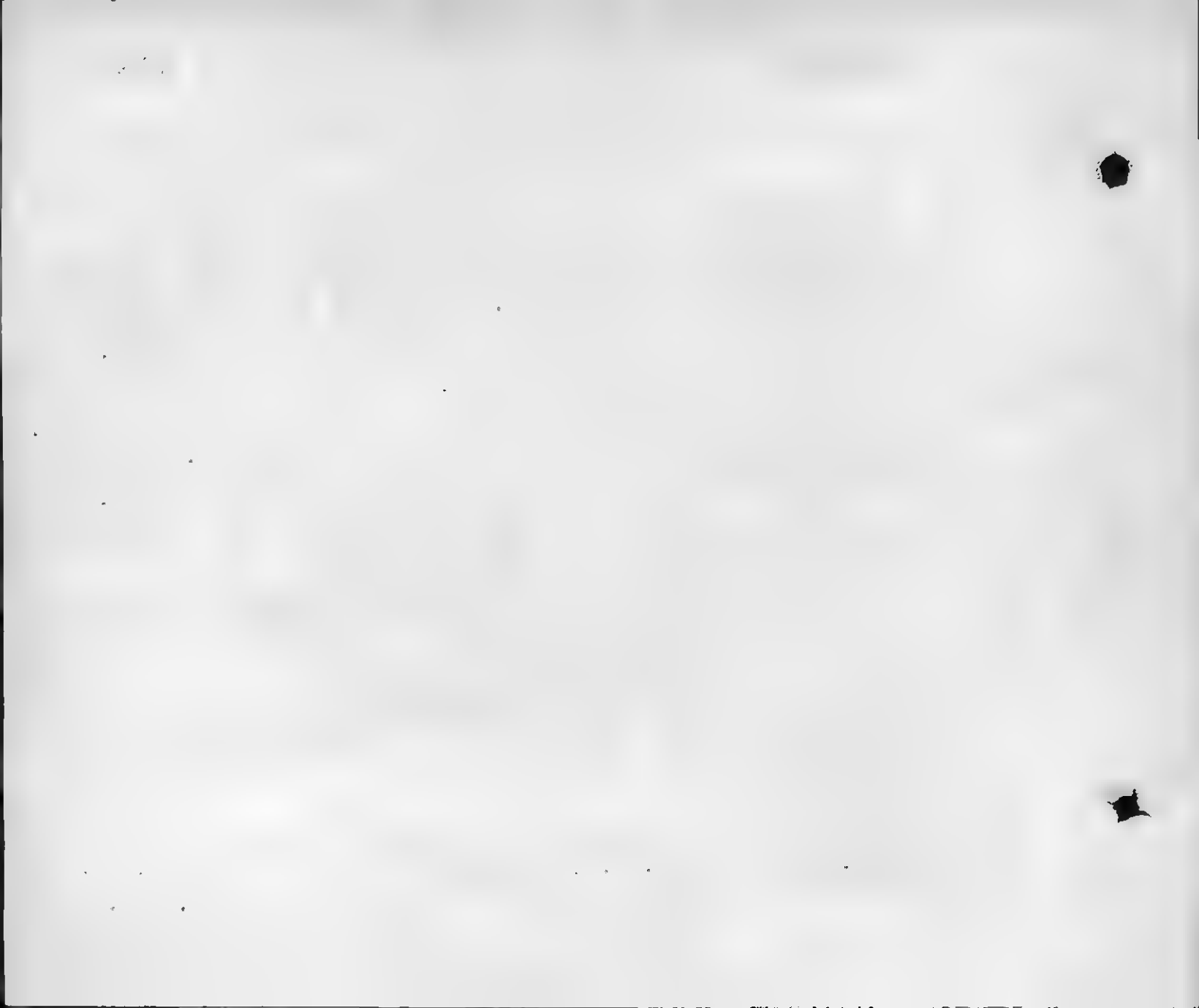
Arthur L. Evans



01816

Ch. 18

VS. AISME, 713
3M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01837

01817

1. PLACE OF DEATH a. COUNTY <u>2nd DEPT.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P. S. S. Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FRANCIS</u> Last <u>KIRK</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. Loren Kirk</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrhythmia</u> + X DUE TO (b) <u>general interstitial emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>2-25-1962</u> to <u>2-22-1962</u> , that (I) (we) last saw the deceased alive on <u>2-22-1962</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis H. Kirk</u>		22b. DATE SIGNED <u>2-22-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis H. Kirk</u>		22d. ADDRESS <u>ES H Prince Georges</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-25-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Coloma, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Kirk</u>		25a. REC'D BY REGISTRAR <u>—</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>FEB 26 '62</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01838

CERTIFICATE OF DEATH

ICSM 2 Film G307 2/26/62 iwk

01818

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admision) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge, Md.	
c. LENGTH OF STAY IN 1b 2 Years		d. STREET ADDRESS 119 Locust St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glasgow Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adeline	FIRST Adeline	MIDDLE Lewis	LAST Lewis
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (in years last birthday) 91 yrs.
11. BIRTHPLACE (County & State, or foreign country) Vienna, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin B. Lewis		14. MOTHER'S MAIDEN NAME Margaret Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Willis Brannock		Address Race St. Ext. Camb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/8 1962 to 2/11 1962, that (I) (we) last saw the deceased alive on 2/10 1962, and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Alfred R. Maryanov		22b. DATE SIGNED 2/14/62	
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		22d. ADDRESS 136 RACE ST. CAMBRIDGE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 13, 1962	23c. NAME OF CEMETERY OR CREMATORY Antioch Churchyard	23d. LOCATION (City, town or county) (State) Antioch, Md.
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		25a. REC'D BY REGISTRAR DATE FEB 15 '62	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Walter S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

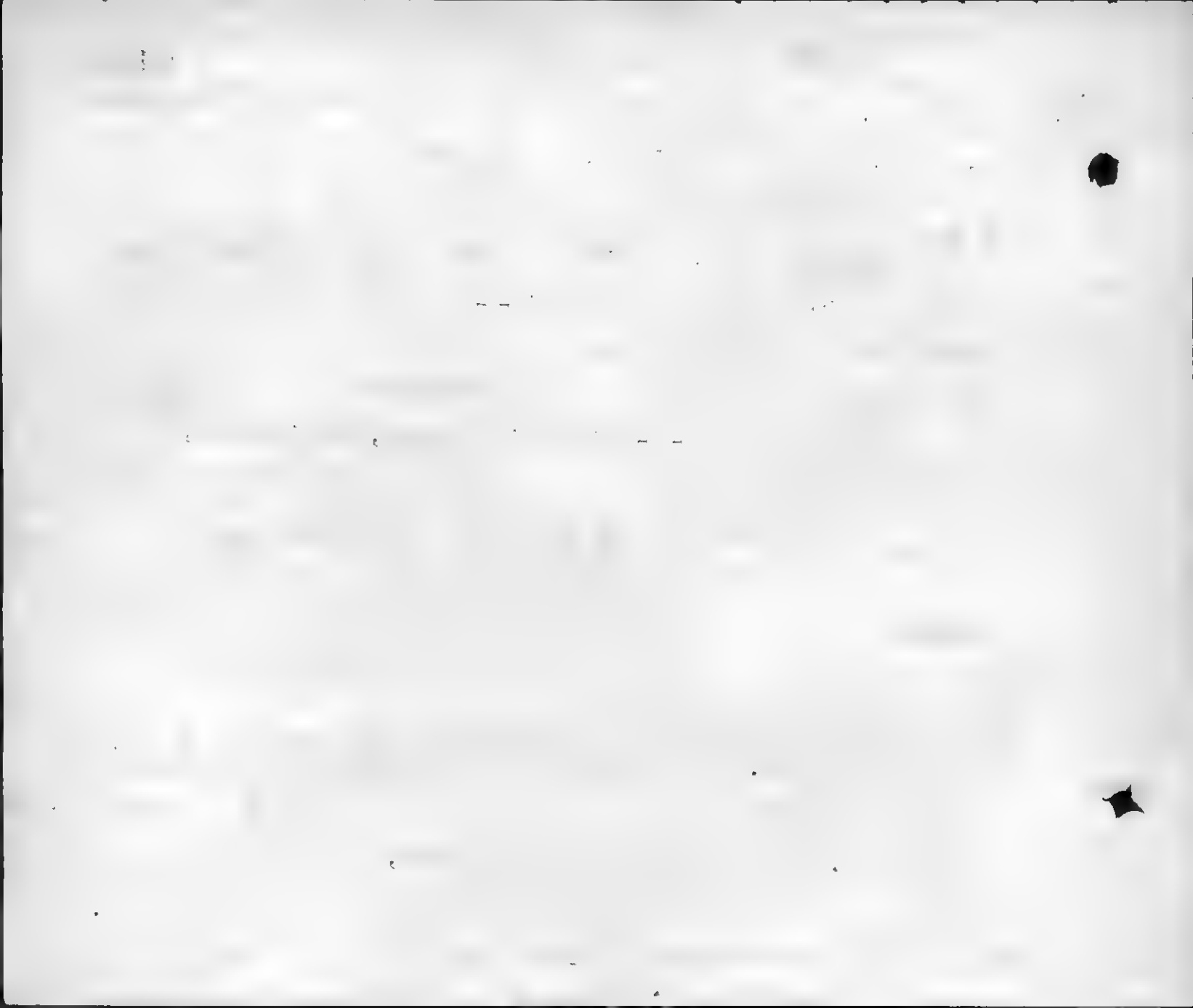
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01839

CERTIFICATE OF DEATH

01819

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Cambridge c. LENGTH OF STAY in 1b 10 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 113 Muse Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Reid Last Little		4. DATE OF DEATH Month February Day 13 Year 1962	
5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-2-01 9. AGE (In years and birthday) 60 IF UNDER 1 YEAR: Months 60 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory worker 10b. KIND OF BUSINESS OR INDUSTRY American Can 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Little 14. MOTHER'S MAIDEN NAME Emma Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unk 16. SOCIAL SECURITY NO. 212-09-5422 17. INFORMANT Medical Records, ESSH Cambridge, Md Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) INTRACTABLE SHOCK (b) DUE TO 20. 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, ACUTE ANTERO-LATERAL MYOCARDIAL INFARCT HYPERTENSIVE ARTERIOSCLEROTIC C. V. D. (c) 3 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THYROTOXICOSIS INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 4-5 DAYS? 3 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that 1 (this hospital) attended the deceased from 6/7/51 to 2/13 , 19 62 , that 1 (we) last saw the deceased alive on Feb. 13 , 19 62 , and that death occurred at 9:40 am , from the causes and on the date stated above. 22a. SIGNATURE Geo M Dunn 22c. PHYSICIAN'S NAME (Type) George M. Dunn 22b. DATE February 13, 1962 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Cambridge, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) 13 23b. DATE THEREOF 2/14/62 23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery 23d. LOCATION (City, town or county) (State) East New Market, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeralservice Comb. Md. ADDRESS		25a. REC'D BY REGISTRAR DATE 8 20 '62 25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01820

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock R.F.D. c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shiloh		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hurlock R.F.D. d. STREET ADDRESS Shiloh	
3. NAME OF DECEASED (Type or print) Alonzo Washington Marine		4. DATE OF DEATH February 17 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired)		10b. KIND OF BUSINESS OR INDUSTRY American Stores Co.	11. BIRTHPLACE (State or foreign country) Dorchester County, Md.
13. FATHER'S NAME William J. Marine		14. MOTHER'S MAIDEN NAME Martha Wheatley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-12-0864	
17. INFORMANT Mrs. Inez Marine, Hurlock, Md. R.F.D.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace, Jr. EXAMINER'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF February 20, 1962	
22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery		22d. LOCATION (City, town, or country) (State) Hurlock Maryland	
23. FUNERAL DIRECTOR J.J. Framptom and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR FEB 27 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01821

1. PLACE OF DEATH
a. COUNTY Dorchester MARYLAND
b. CITY OR TOWN (If outside corporate limits, give nearest town) Rhodesdale c. LENGTH OF STAY IN TOWN 51 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE MD b. COUNTY Dor
c. CITY OR TOWN (If outside corporate limits, give nearest town) Rhodesdale
d. STREET ADDRESS _____

3. NAME OF DECEASED (Type or print) Otho First Winfield Middle McWilliams Last
4. DATE OF DEATH 2 Month 12 Day 1962 Year
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 1879 82 yrs. 9. AGE (In years last birthday) 82 yrs. 10. IF UNDER 1 YEAR Months 2 Days 10 Hours 10 Min. 11. IF UNDER 24 HRS. Months 2 Days 10 Hours 10 Min. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming, Own Farm, Maryland 11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Daniel McWilliams 14. OTHER'S MAIDEN NAME Cecelia Payne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Harvey McWilliams ADDRESS Rhodesdale

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE (e) Cardiac arrest -
(b) Complete heart block -
(c) Arteriosclerotic heart disease -
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Insulin diabetes mellitus
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____

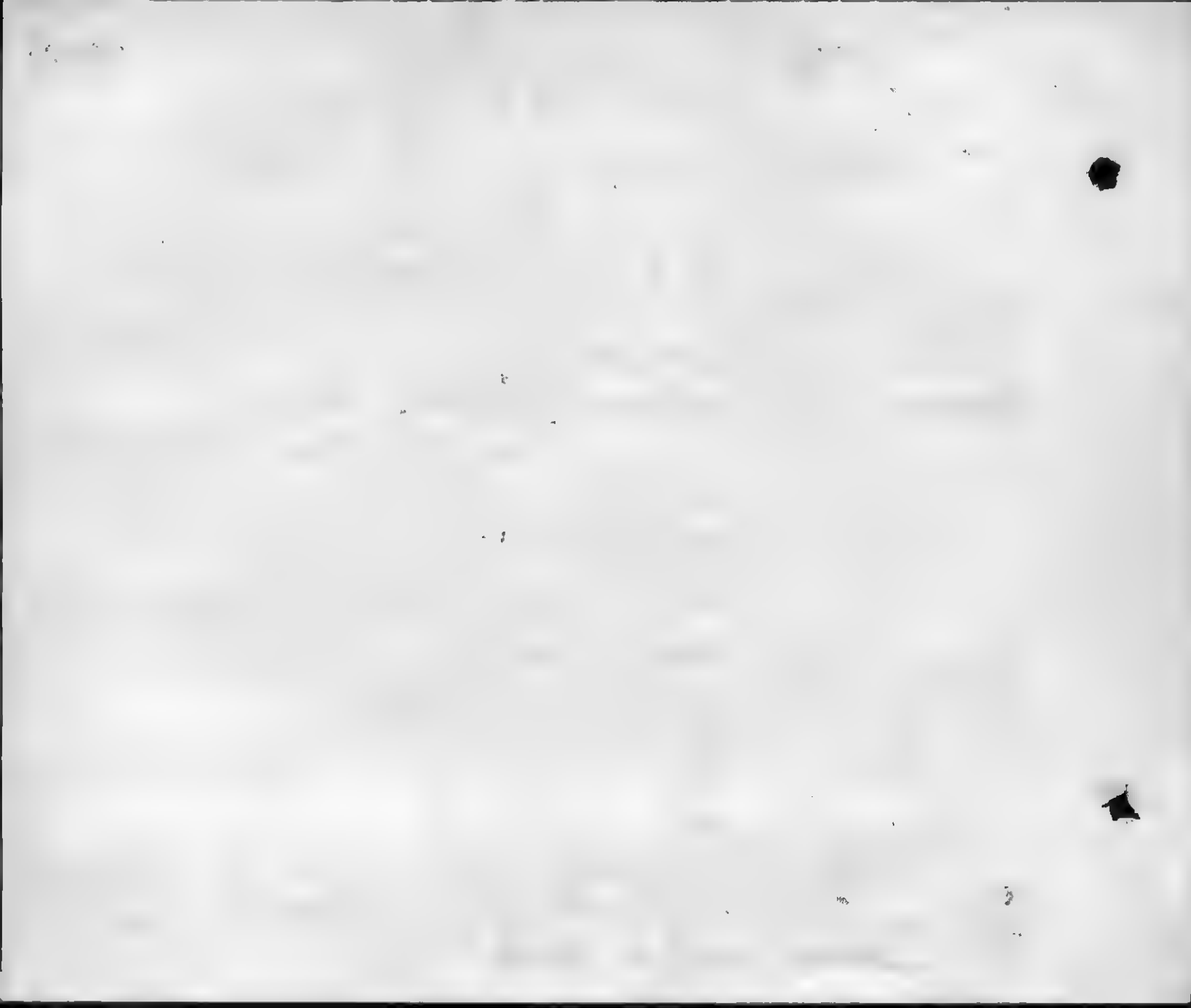
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ Not While ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that (I) (this hospital) attended the deceased from 8-17-1957 to 2-20-62, 1962 that (I) (we) last saw the deceased alive on 2-17-62, 1962 and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE Harold B. Plummer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED _____
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer 22d. ADDRESS Preston, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral 23b. DATE THEREOF 2/23/62 23c. NAME OF CEMETERY OR CREMATORY Washington 23d. LOCATION (city, town or county) Lurlock (State) MD

24. FUNERAL DIRECTOR'S SIGNATURE Ruth S. Wilkings ADDRESS East New Market 25a. REC'D BY REGISTRAR 27 25b. REGISTRAR'S SIGNATURE C. L. 27 DATE FEB 27 '62



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

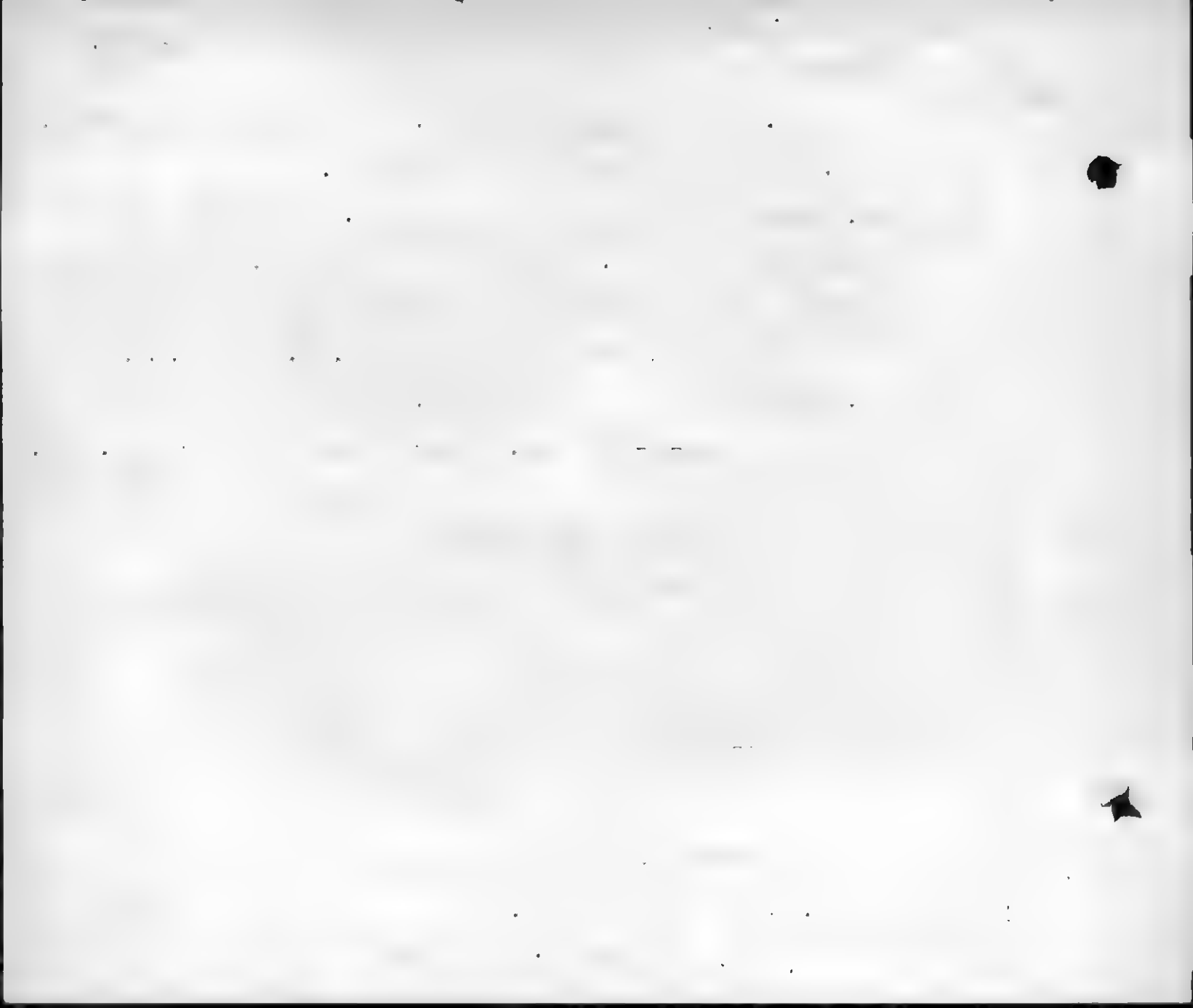
CERTIFICATE OF DEATH

01842

01822

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> c. LENGTH OF STAY IN lb <u>40 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u> d. STREET ADDRESS <u>200 Locust St.</u> e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence F. Mitchell</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>4,</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1887</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver W. Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Laura L. Price</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-9634</u>	
17. INFORMANT <u>Mrs. Clarence Mitchell</u>		Address <u>200 Locust St. Camb.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Renal failure</u> (b) <u>Conjunctive heart failure</u> (c) <u>Arteriosclerotic cardio vascular renal disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>2 weeks</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1-8-62</u> <u>2-4</u> <u>1962</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-4</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> <u>1962</u> , and that death occurred at <u>9A</u> <u>M</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Eldridge H. Wolff</u>		22b. DATE SIGNED <u>2-4-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		22d. ADDRESS <u>15 Locust St., Cambridge, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 6, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>	
ADDRESS <u>Cambridge, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Long S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

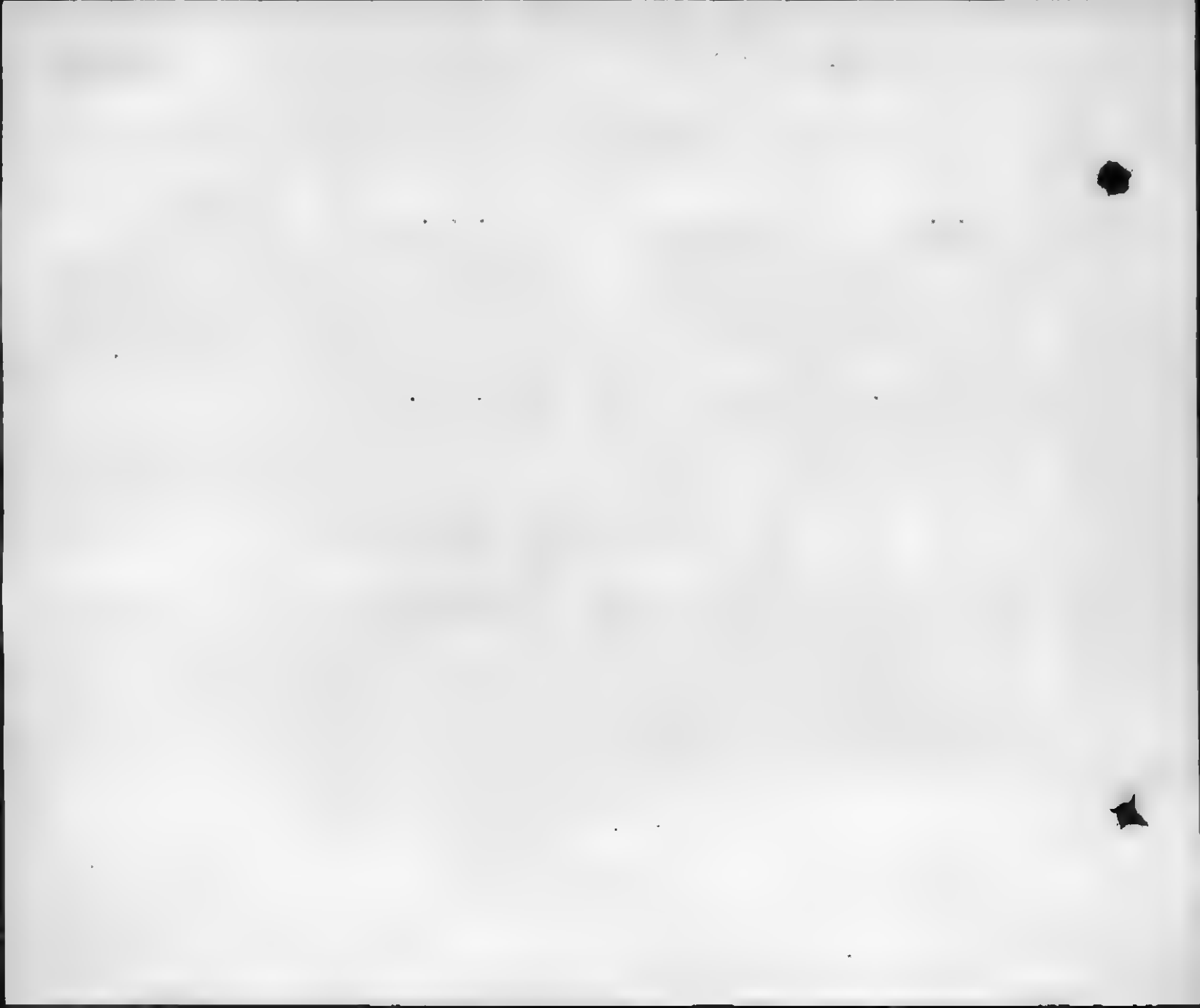
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01823

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Vienna c. LENGTH OF STAY IN lb Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. -- Steeles Neck		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Vienna d. STREET ADDRESS R.F.D. Steeles Neck e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew Richard Mollock		4. DATE OF DEATH Feb. 24 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 7 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew R. Sampson		14. MOTHER'S MAIDEN NAME Ruth A. Mollock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ruth Mollock		Address Vienna, Md. R.F.D.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 47- DUE TO (b) Acute respiratory infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. John Hace Jr.		DATE SIGNED 2/26/62	
EXAMINER'S NAME (Type) Dr. John Hace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/25/62	
22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		22d. LOCATION (City, town, or country) Salem, Dorchester, Md.	
23. FUNERAL DIRECTOR Herbert St. Clair		ADDRESS Cambridge, Md.	
24a. REC'D BY REG STRAR FEB 28 '62		24b. REGISTRAR'S SIGNATURE Charles S. Hance	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

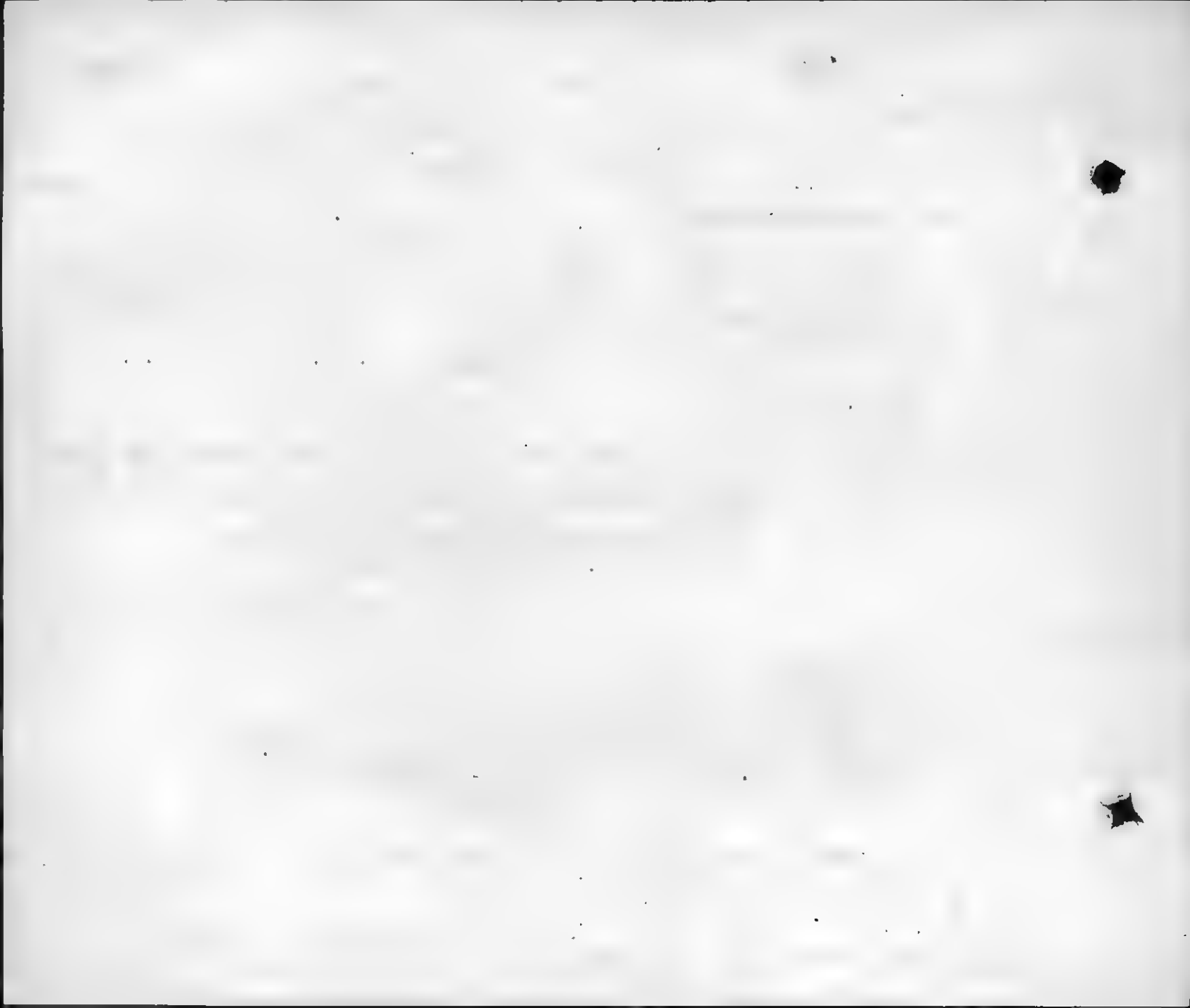


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01844
01825
01825

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolfords d. STREET ADDRESS Woolfords, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY in 1b 11 months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital					
3. NAME OF DECEASED (Type or print) ALTON		First Middle Last		4. DATE OF DEATH February 20, 1962	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10/12/81		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days 19 Months 10 Days	
11. BIRTHPLACE (County & State, or foreign country) Maryland U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John R. Neild		14. MOTHER'S MAIDEN NAME Hester Ann Neal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-2358		17. INFORMANT Medical Records of Eastern Shore State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis with cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome associated with Senile Brain Disease, with psychotic reaction DUE TO (c) Unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 7, 1961, to Feb. 20, 1962	
20f. (City or town) 130		20g. (County) 130		20h. (State) 130	
21. I certify that 10 (this hospital) attended the deceased from March 7, 1961 , to Feb. 20, 1962 that (I) 130 last saw the deceased alive on Feb. 19, 1962 , and that death occurred at 130 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Simon Virkutis					
22b. DATE SIGNED 2/20/1962					
22c. PHYSICIAN'S NAME (Type) Simon Virkutis					
22d. ADDRESS Eastern Shore State Hospital, Cambridge, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Old Trinity Churchyard	
23d. LOCATION (City, town or county) Church Creek, Maryland		23e. REC'D BY REGISTRAR FEB 26 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Hines	
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Svc., Cambridge, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

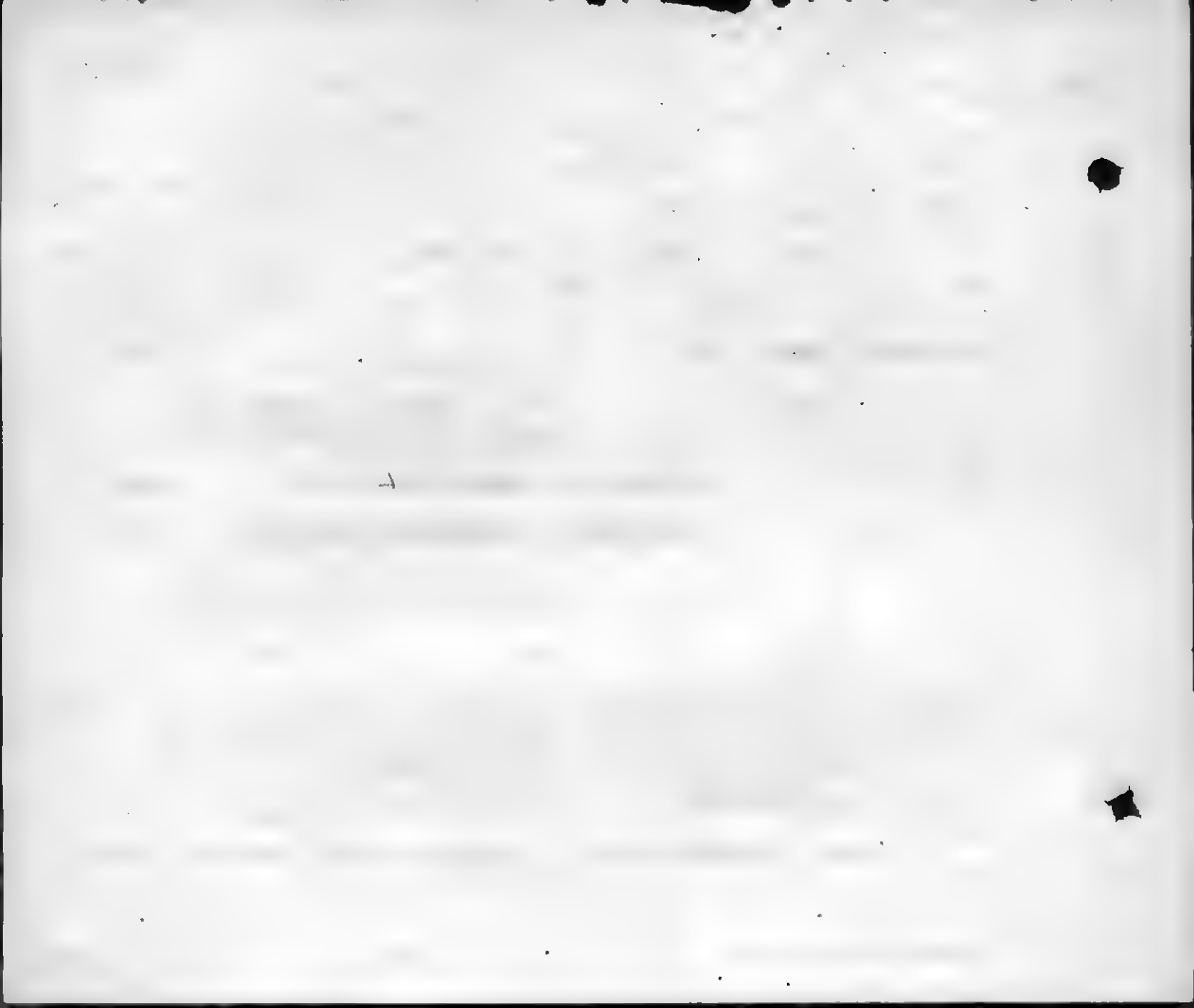
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01845

01826

1. PLACE OF DEATH a. COUNTY <u>Cambridge</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mary</u> b. COUNTY <u>Man</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROCKTON, 8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp</u>		d. STREET ADDRESS <u>10 Columbia Street</u>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>ANNA</u> Last <u>PALMER</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Whitlurst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Sister</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CERERAL ARTERIOSCLEROSIS</u> DUE TO (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-18</u> , 19 <u>62</u> , to <u>2-5</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>62</u> , and that death occurred at <u>15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Jacob Morgenstern</u>		22b. DATE SIGNED <u>2-5-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JACOB MORGENSTERN</u>		22d. ADDRESS <u>Eastern Shore State Hospital, Cambridge, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 7, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Church Creek, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>	
ADDRESS <u>Cambridge, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Carroll J. Thomas</u>	



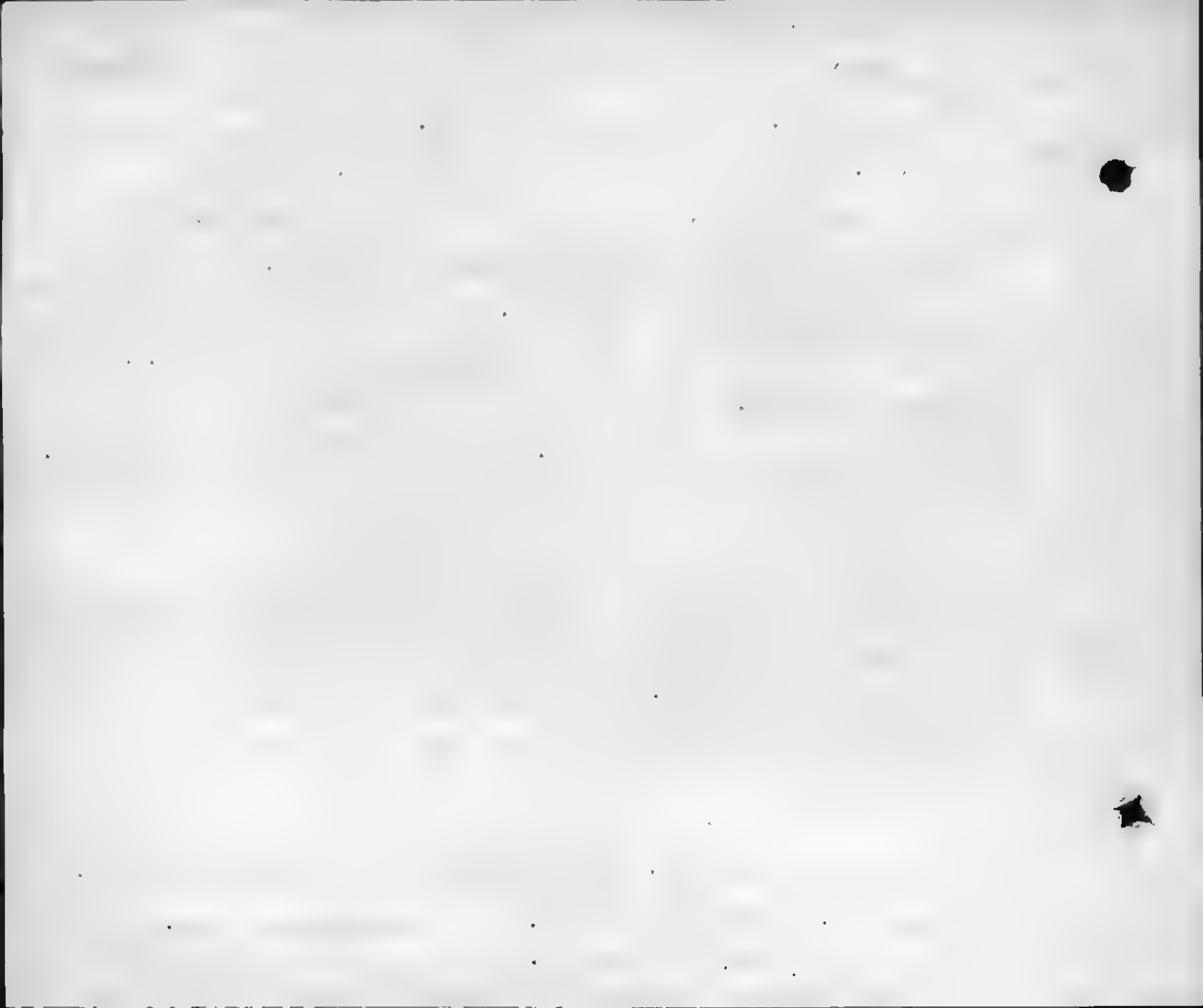
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AIME
SM 9 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 13 Cambridge, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Cedars, Cambridge, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Douglas Howard Phillips		4. DATE OF DEATH Feb. 4, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1944	
9. AGE (In years last birthday) 17 yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months 4 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albanus Phillips Jr.		14. MOTHER'S MAIDEN NAME Anita Spedden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Phillips		Address The Cedars Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide asphyxiation DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1962	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		22d. LOCATION (City, town, or country) (State) Cambridge Md.	
23. FUNERAL DIRECTOR LeCompte Funeral Service		24. REC'D BY REGISTRAR Feb 13 '62	
24b. REGISTRAR'S SIGNATURE LeCompte		DATE SIGNED 2/7/62	



CERTIFICATE OF DEATH

Reg. Dist. No. **01828****01847**

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital				1 d. STREET ADDRESS 100A Pine St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Pinkett				4. DATE OF DEATH Month February Day 10, Year 62			
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1899		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Pinkett				14. MOTHER'S MAIDEN NAME Henrietta Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO 178-16-7445		17. INFORMANT Miss Sylvia Pinkett-Cambridge, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1961 to February 10, 1962 , that I last saw the deceased alive on February 10, 1962 , and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Cambridge, Md. DATE SIGNED 2-13-62							
ACTUAL SIGNATURE J. Edwin Fassett, M.D.				M. D. 227 Pine St., Cambridge, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-62		22c. NAME OF CEMETERY OR CREMATORY Reidsgrove Cemetery		22d. LOCATION (City, town, or county) (State) Reidsgrove-Dor-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Edwin Fassett				ADDRESS High St., Cambridge, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '62	
				24b. REGISTRAR'S SIGNATURE Caroline E. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01848

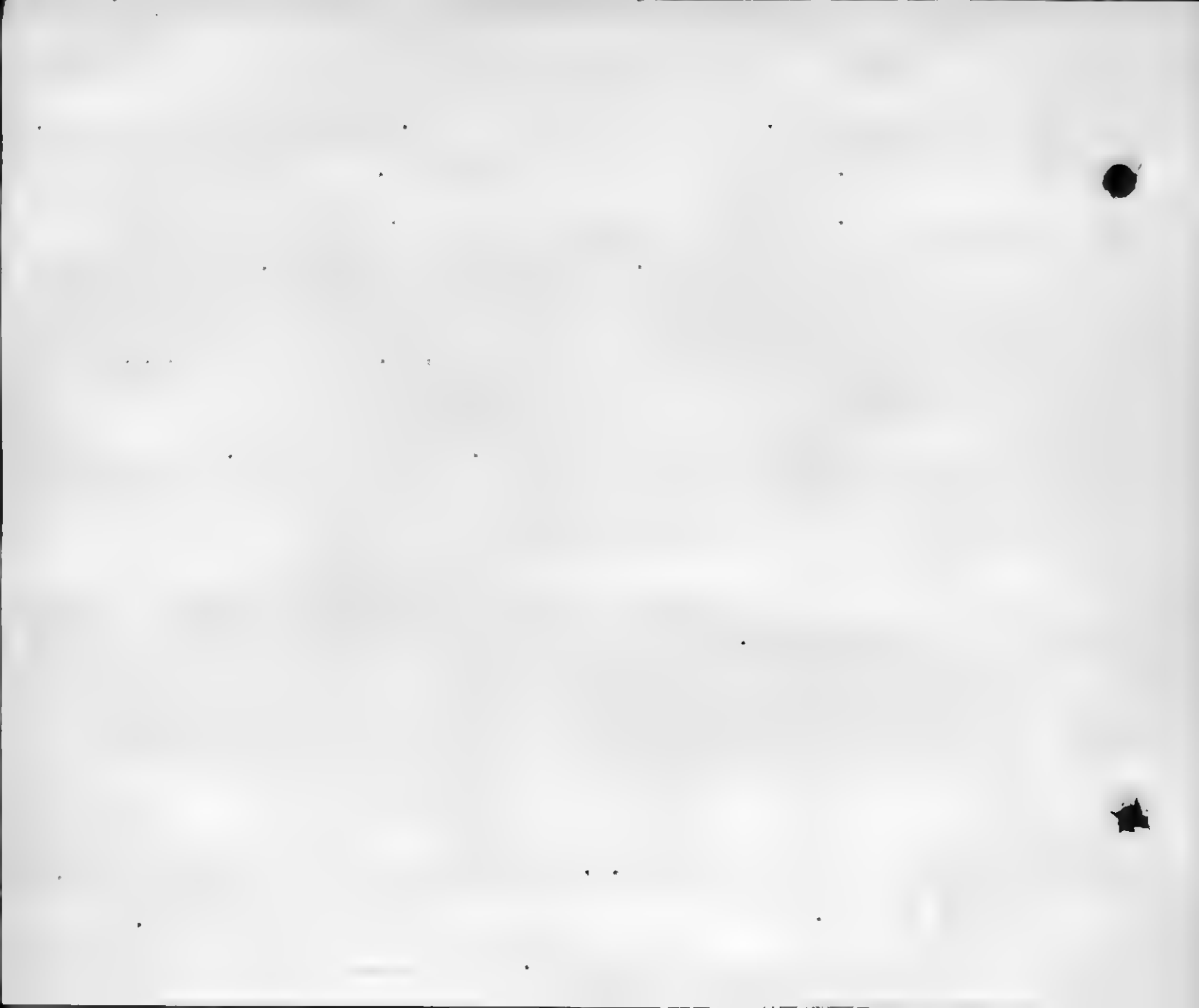
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01829

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Honga, Md.</u>			
c. LENGTH OF STAY IN 1b <u>2 Days</u>				d. STREET ADDRESS <u>Honga, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas L. Ruark</u>				4. DATE OF DEATH <u>Feb. 16, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1871</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>62</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman Fishing</u>				11. BIRTHPLACE (State or foreign country) <u>Honga, Md.</u>			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Ruark</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Alvin G. Ruark</u>				Address <u>Honga, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 Mins.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Virus infection.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr. M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/21/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb. 18, 1962</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hoosier Churchyard</u>				22d. LOCATION (City, town, or country) <u>Cambridge, Md.</u> (State) _____			
23. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>				24a. REC'D BY REGISTRAR <u>FEB 26 '62</u>			
ADDRESS <u>Cambridge, Md.</u>				24b. REGISTRAR'S SIGNATURE _____			

VS. AISME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

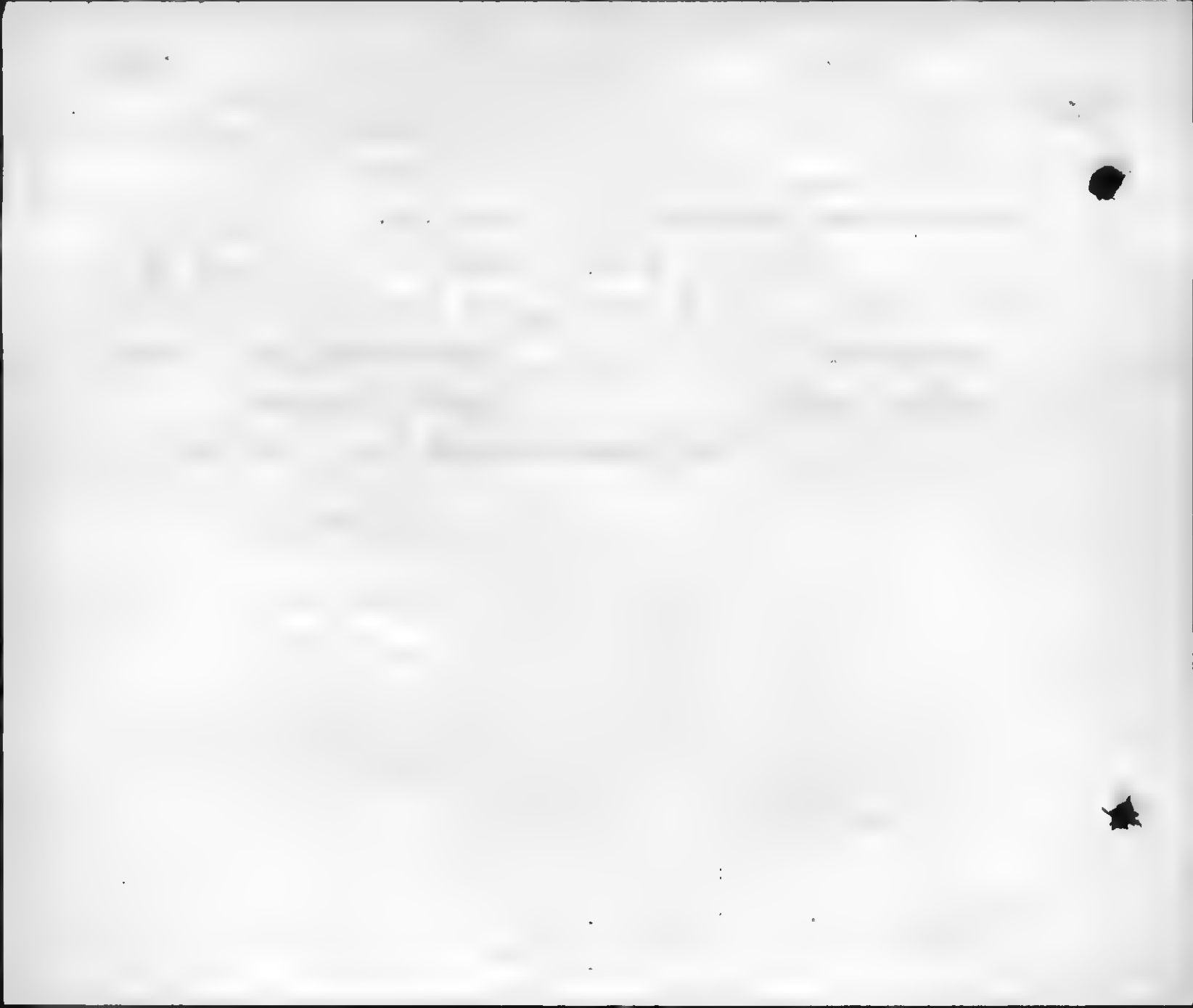
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01849

01830

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate</u> d. STREET ADDRESS <u>Wingate, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Will</u> <u>Westo</u> <u>Scott</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1876</u>	9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u>
13. FATHER'S NAME <u>Albert Scott</u>		14. MOTHER'S MAIDEN NAME <u>Tillie Harner</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-3411</u>		17. INFORMANT <u>Mrs. Jane Henry</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 450.00 DUE TO <u>Senility arterio-sclerosis.</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Brain Syndrome</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1,26.62 - 167.62</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u> </u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26, 1962</u> to <u>Feb 17, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 6, 1962</u> and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above				
22a. SIGNATURE <u>John F. Schneider</u>		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 19, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zion Churchyard</u>	23d. LOCATION (City, town or county) <u>Toddville,</u>	(State) <u>Maryland,</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Compton Jr Cambridge, Md</u>		25a. REC'D BY REGISTRAR <u>FEB 20 1962</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

01850

Item 7 Film G-208

3/2/62 IWF

01831

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Cambridge Maryland Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Maryland

b. COUNTY

Dorchester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

d. STREET ADDRESS

419 High St.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Eva

Middle

Last

Smith

4. DATE OF DEATH

Month

Day

Year

Feb. 19, 1962 19

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Jan. 10, 1898

9. AGE (In years last birthday)

64 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Chester

14. MOTHER'S MAIDEN NAME

Effie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

221-14-7051A Helen Smith, Wilmington, Del.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)

Diabetic coma

INTERVAL BETWEEN ONSET AND DEATH
Abt. 3 hrs.

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I, of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Dr. John Mace Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

2/27/62

Address (Street, city, town or county)

Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2/22/62

22c. NAME OF CEMETERY OR CREMATORY

Beckwith Cemetery

22d. LOCATION (City, town, or county)

Dorchester County, Md.

23. FUNERAL DIRECTOR

ADDRESS

Herbert St. Clair

Cambridge, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE FEB 28 '62

C. J. Mace

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01851

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01832

1. PLACE OF DEATH

a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Church Creek

c. LENGTH OF STAY IN

All life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)

e. STATE

Maryland

b. COUNTY

Dorchester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Church Creek

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

George Edward Stanley

4. DATE OF DEATH

Month

Day

Year

Feb. 14 19 62

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED

☒ NEVER MARRIED ☐

☐ WIDOWED ☐

☐ DIVORCED ☐

8. DATE OF BIRTH

3/29/13

9. AGE (In years last birthday)

48 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Gen. Labor

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henson Stanley

14. MOTHER'S MAIDEN NAME

Julia Nichols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

216-12-1653

17. INFORMANT

Anna E. Stabley

Address

Church Creek, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Carcinoma of bladder

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 a)

INTERVAL BETWEEN ONSET AND DEATH

?

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John Mace Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

2/14/62

22a. BURIAL, CREMATION, or REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

FEB 23 '62

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

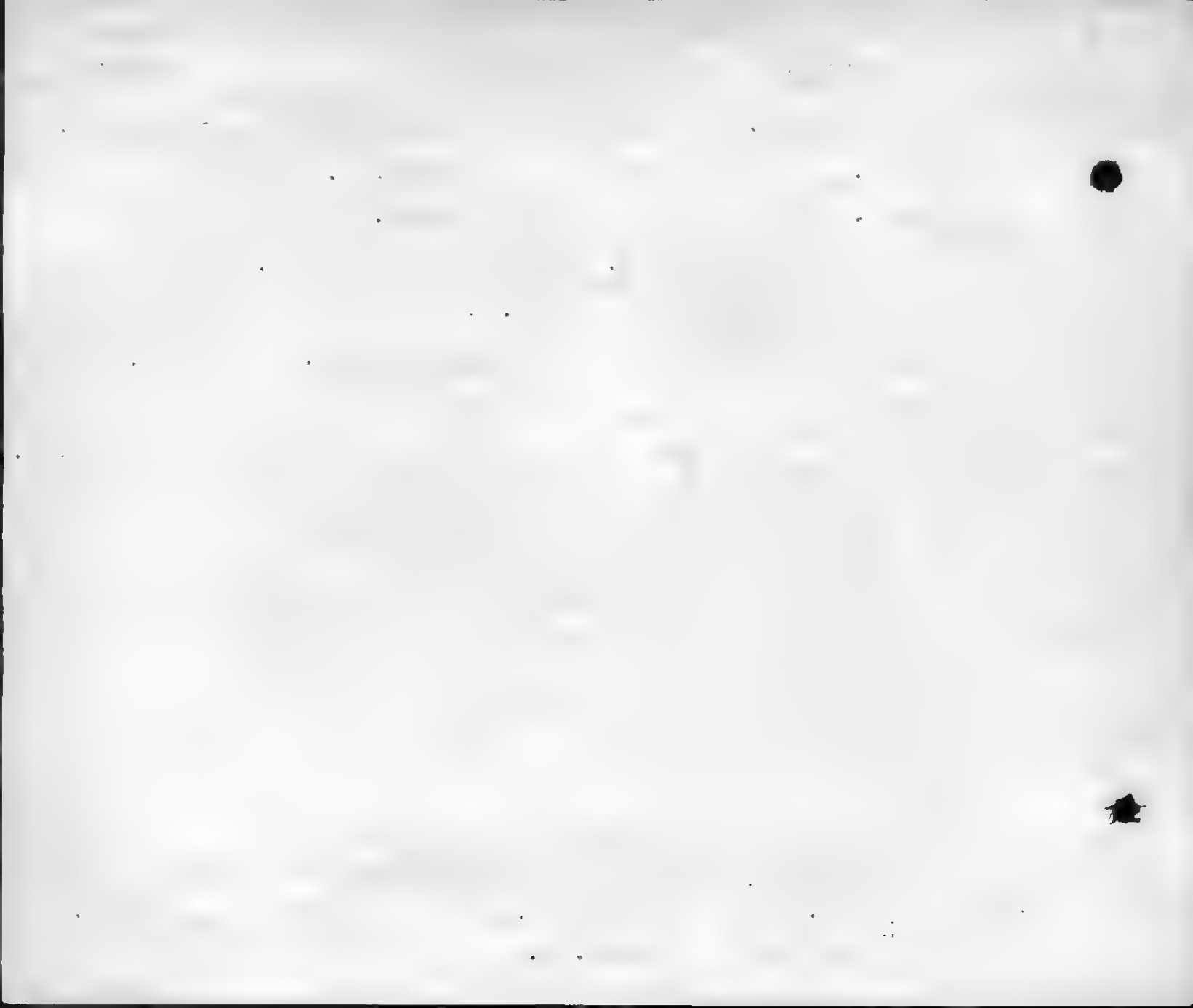
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01852

03165

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>300 Race St.</u>		d. STREET ADDRESS <u>300 Race St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gordy</u> Middle <u>E.</u> Last <u>Tall</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5, 1871</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bishops Head, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Tall</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mace Tall</u>		Address <u>300 Race St. Cambridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Arteriosclerotic Nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13/62</u> , 19 <u> </u> , to <u>2/22/62</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/22</u> , 19 <u> </u> , and that death occurred <u>6:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence Maryanov</u> M.D.		22b. ADDRESS <u>Cambridge</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		22d. ADDRESS <u>Cambridge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 25, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>	
ADDRESS <u>Cambridge, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



FOR STATE
HEALTH DEPT.

M

17

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VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Dor</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Dor</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <u>High St.</u>		g. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1962</u>		h. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
3. NAME OF DECEASED (Type or print) <u>Flora Rickwood Tompkins</u>		4. SEX <u>Female</u>		5. COLOR OR RACE <u>White</u>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. DATE OF BIRTH <u>10/9/1880</u>	
8. AGE (In years last birthday) <u>81</u>		9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		10. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William G. Rickwood</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Young</u>		15. ADDRESS <u>Mr. Ross Smith, East New Market, Md.</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mr. Ross Smith, East New Market, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>4</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause first. <u>Fracture shaft of femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture shaft of femur</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell in her home.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12/19/61</u> p.m. <u>12/19/61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cambridge, Dor.</u>		(County) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/9/62</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		NAME (Type) <u>John Mace Jr.</u>		ADDRESS (Street, city, town, or county) <u>Cambridge, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. LOCATION (City, town, or county) <u>Cambridge, Md.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cerie</u>		22d. LOCATION (City, town, or county) <u>Cerie, Tenn.</u>		(State) <u>Tenn.</u>	
23. FUNERAL DIRECTOR <u>Luth. S. Millongby</u>		ADDRESS <u>East New Market, Md.</u>		24a. REC'D BY REGISTRAR <u>13 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>		DATE <u>13 '62</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01834

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 40 Years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		d. STREET ADDRESS 308 Peach Blossom Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary K. Travers		4. DATE OF DEATH Feb. 7, 1962		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 30, 1900		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Fishing Creek, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel H. Tolley		14. MOTHER'S MAIDEN NAME Cora Ruark		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Eulan Travers		Address 308 Peach Blossom Ave.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion -20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 15 mins.									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/8/62							
ACTUAL SIGNATURE John Mace Jr.		M.D.		EXAMINER'S NAME (Type) Dr. John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.		22d. LOCATION (City, town, or county) (State)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 9, 1962		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park		22d. LOCATION (City, town, or county) Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 13 '62							
23. FUNERAL DIRECTOR LeCompte Funeral Service		ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE L. S. Mace											



1.
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained to your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

M

16

I

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

John Mace Jr.

22b. DATE THEREOF

23. FUNERAL DIRECTOR

Robert H. Watson

ADDRESS

Pocomoke City, Md.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fracture neck r. Femur

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

10:30AM

1-19-1962

20d. INJURY OCCURRED

White ☐ Not White ☒
at work ☐ at work ☒

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Hospital

20f. (City or town)

Cambridge

(County)

Dor.

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

2/18/62

24a. REC'D BY REGISTRAR

FEB 23 '62

24b. REGISTRAR'S SIGNATURE

J. L. Hume

1. PLACE OF DEATH

a. COUNTY

Dorchester

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cambridge

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

E.S. State Hospital

MARYLAND

c. LENGTH OF STAY IN 1b

3 yrs.

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)

a. STATE

Md.

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City

d. STREET ADDRESS

402 Laurel Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First Purla

Middle Anna

Last (Wessels)

Wessels

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5/29/76

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Thornton

14. MOTHER'S MAIDEN NAME

-Unknown

Jennie Kilmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Records E.S.S. Hospital. Cambridge, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUETO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUETO

(c)

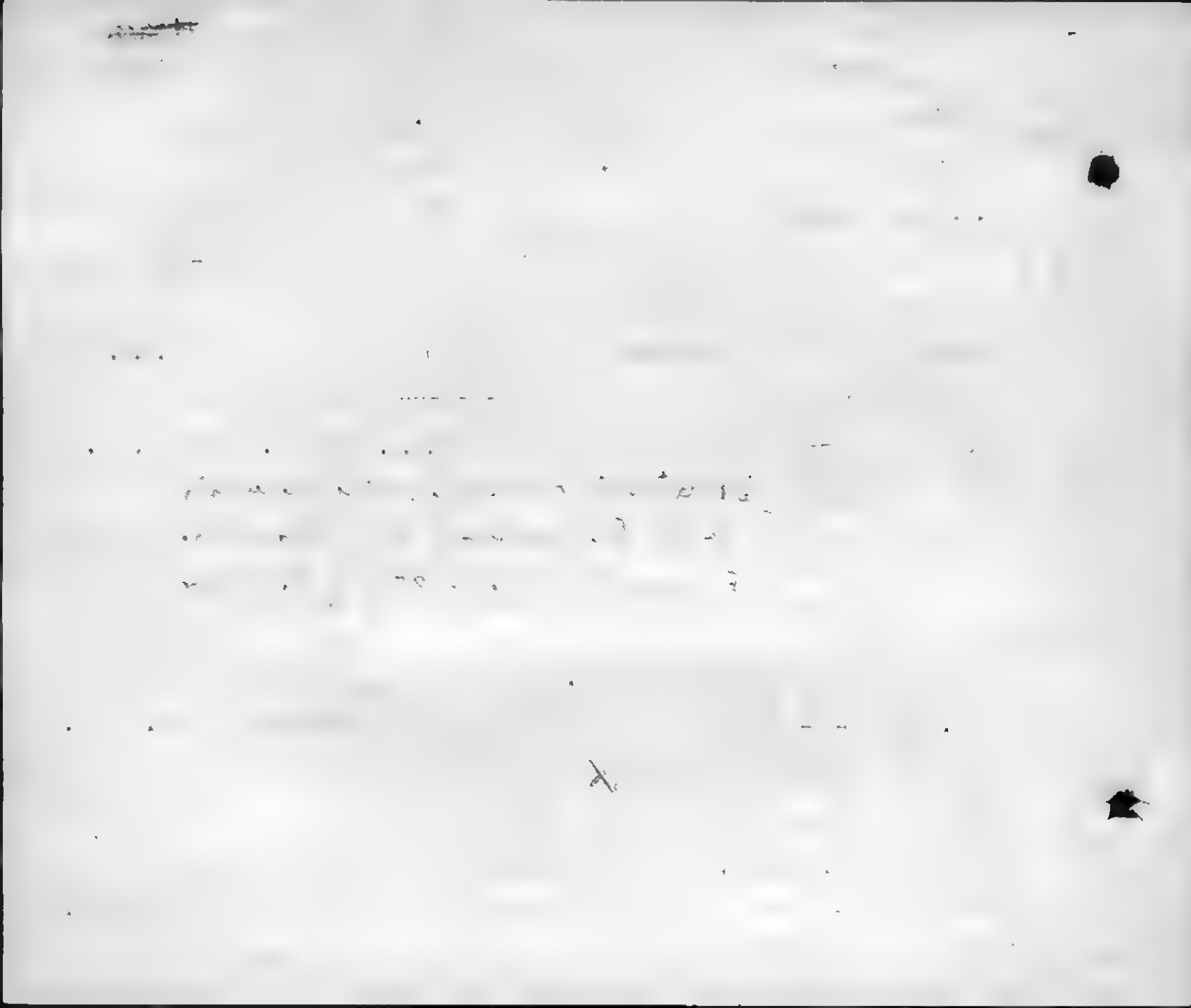
Bilateral broncho pneumonia and Pulmonary embolism, R. Fracture of neck of R. femur

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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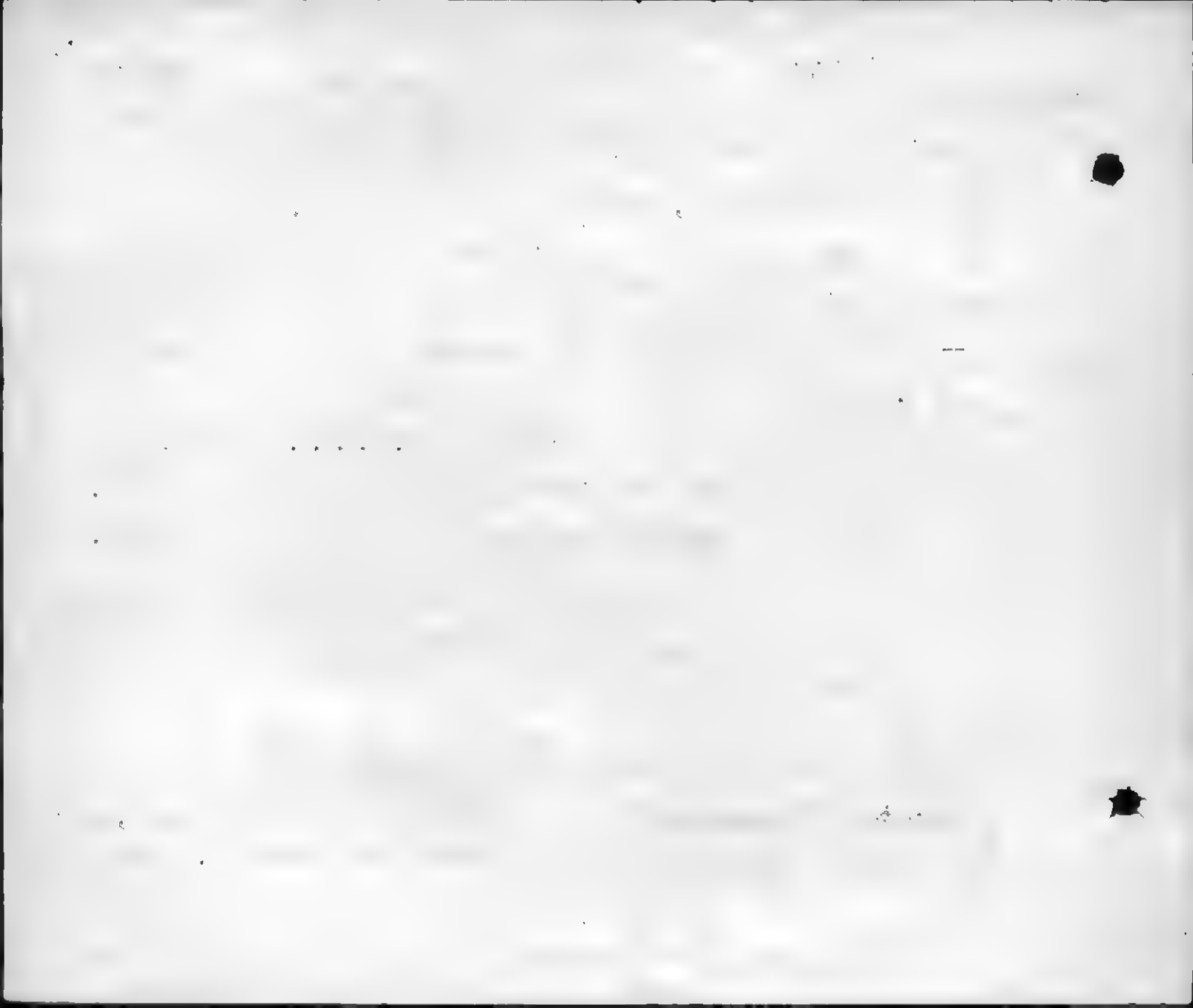
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01856

03172

1. PLACE OF DEATH a. <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u> c. LENGTH OF STAY in 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital, Cambridge</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>207 Franklin St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Maggie</u>		First Middle Last <u>Williams</u>		4. DATE OF DEATH Month Day Year <u>Feb 22 19 62</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09/05/70</u>	9. AGE (In years last birthday) <u>91</u> yrs	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>John M. Williams</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Medical Records, E.S.S.H. Cambridge, Md</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>4-4-X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General Arteriosclerosis</u> (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. plus</u> <u>1 yr. plus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> <u>1961</u> to <u>2/22</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>Feb 22</u> <u>1962</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Jacob Morgenstern</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Feb 22, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Jacob Morgenstern</u>		22d. ADDRESS <u>Eastern Shore State Hosp. Cambridge, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>			
				23d. LOCATION (City, town or county) (State) <u>Cambridge, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edto Compton</u>		ADDRESS <u>Cambridge, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01857 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9. Film G308 3/12/62 iwk

01836

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY in it Life		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 418 High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Garfield		First		Middle		Last		4. DATE OF DEATH February 7 1962		Month		Day	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 21, 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph W. Woolford		14. MOTHER'S MAIDEN NAME Katherine Dorsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-0510A		17. INFORMANT Nicey Payne Rt. 3. Cambridge, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 493x		Pneumonia		DUE TO		DUE TO		DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 week.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/22/62		Cambridge, Md.			
ACTUAL SIGNATURE Dr. John Mace Jr. M.D.		EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/62		22c. NAME OF CEMETERY OR CREMATORY Christ Rock Cemetery		22d. LOCATION (City, town, or country) Dorchester Co. Md.			
23. FUNERAL DIRECTOR Herbert St. Clair		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR FEB 22 1962		24b. REGISTRAR'S SIGNATURE C. S. S. House							

...
TWO FOR ONE CERTIFICATE - FIRM 620 - 3/7 - 2nd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

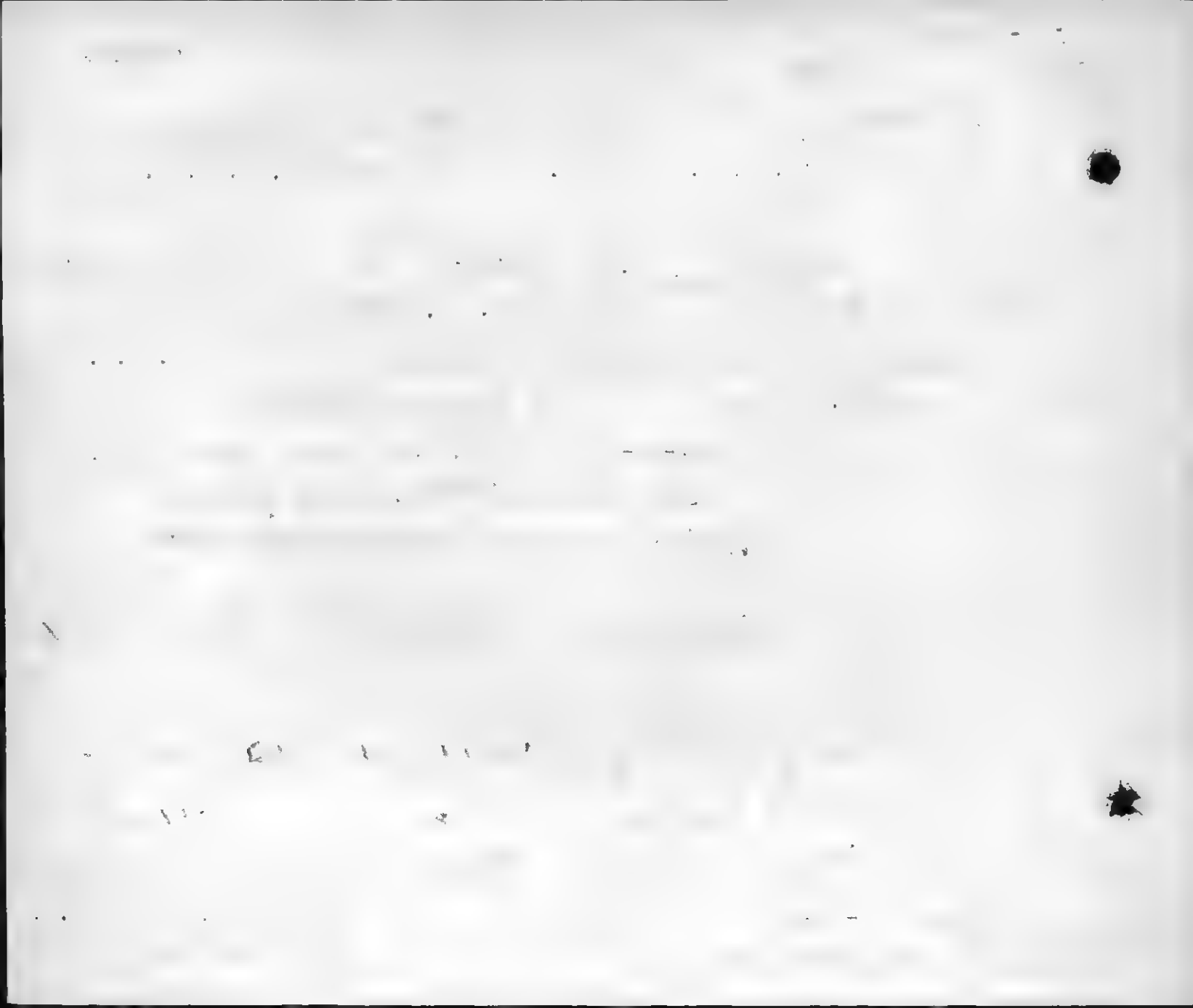
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01858

01837

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg R. F. D. c. LENGTH OF STAY IN It 30 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg, R. F. D. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle F. Last Wright				4. DATE OF DEATH Month Feb. Day 12 Year 1962			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 18, 1864			
9. AGE (In years last birthday) 78 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John W. Wright				14. MOTHER'S MAIDEN NAME Lovey Payne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 215-36-2091			
17. INFORMANT Mrs. Cora Wright Federalburg, R. F.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1 DUE TO Coronary Thrombosis, acute Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (a hospital) attended the deceased from 12-17, 1961 to 2-12, 1962 that (I) last saw the deceased alive on 2-6-62 and that death occurred at 11:30 A.M. from the causes and on the date stated above.				22a. SIGNATURE John C. Rawlin 2-17-62 John C. Rawlin M.D. Shipley & Spruce Sts., Sea Ford, Del.			
22c. PHYSICIAN'S NAME (Type) John C. Rawlin				22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-15-62			
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION (City, town or county) (State) Federalburg, Md. R. F. D.			
24. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Nelson				25a. REC'D BY REGISTRAR DATE FEB 23 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Kneib							



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

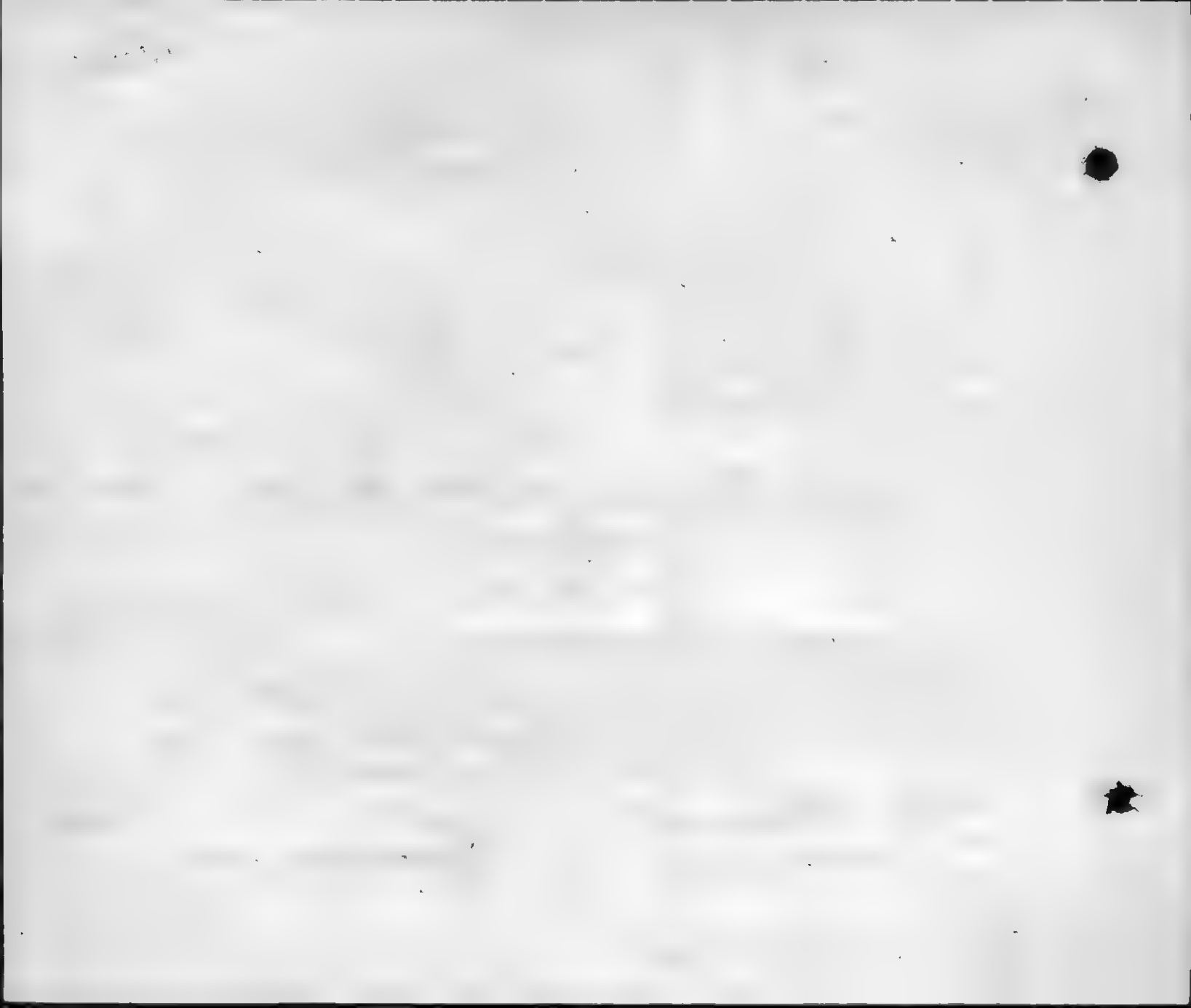
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01859

01838

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY (in weeks) <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge, Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if last full one; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Brice Maxwell Wroten</u> First Middle Last		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hebster C. Wroten</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Hilley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>CH</u> INFORMANT <u>Mrs. Brice Wroten</u> Address <u>East New Market</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Coronary Artery thrombosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Residual Hemiplegia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> to <u>4/5</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>4/5</u> , 19 <u>62</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W.H.H. Hanks</u>		22b. DATE SIGNED <u>2/8/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H.H. HANKS</u>		22d. ADDRESS <u>CAMBRIDGE Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		23b. DATE THEREOF <u>2/7/62</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>East New Market</u>		23d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Hillyoughy</u>		24b. ADDRESS <u>East New Market</u>	
25a. REC'D BY REGISTRAR <u>EB 13 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Hillyoughy</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01860

CERTIFICATE OF DEATH

01839

1. PLACE OF DEATH e. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews, Md.	
c. LENGTH OF STAY IN 1b 2 Days		d. STREET ADDRESS Andrews, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maggie Middle Tyler Last Wroten		4. DATE OF DEATH Month Feb. Day 14 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1896
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Robbins Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Tyler	
14. MOTHER'S MAIDEN NAME Mary Denny		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Norman R. Wroten Andrews, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Brouhaque DUE TO (c) Central Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 day 7 days 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/3 19 62 to 2/14 19 62 that (I) (we) last saw the deceased alive on 2/14/62 19 62 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE W.H. Hanks		22b. DATE SIGNED 2/15/62	
22c. PHYSICIAN'S NAME (Type) W.H. HANKS		22d. ADDRESS Cambridge Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 16, 1962	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	23d. LOCATION (City, town or county) (State) Cambridge, Md.
24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		25a. REC'D BY REGISTRAR FEB 20 62	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge, Md c. LENGTH OF STAY IN Ib 2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital, Cambridge				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS ?134 N. Aurora St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William Middle McHenry Last Yeatman				4. DATE OF DEATH Month February Day 17, Year 19 62					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 7, 1882		9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Shoe Building		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William McHenry Yeatman				14. MOTHER'S MAIDEN NAME Emma Gregory				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None	
16. SOCIAL SECURITY NO. 218-03-1632				17. INFORMANT Medical Records, ESSH Cambridge, Md				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) CACHEXIA & DEHYDRATION DUE TO (c) ARTERIOSCLEROTIC C.V.D. & PERIPHERAL COLLAPSE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from May 5 , 19 59 to Feb. 17 , 19 62 , that (1) (we) last saw the deceased alive on Feb. 17 , 19 62 , and that death occurred at 10:35 P.M. from the causes and on the date stated above.	
22a. SIGNATURE George M. Dunn				22b. DATE SIGNED Feb 17, 1962		22c. PHYSICIAN'S NAME (Type) George M. Dunn		22d. ADDRESS Eastern Shore State Hosp, Cambridge, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 20, 1962		23c. NAME OF CEMETERY OR CREMATORY Lardis Cemetery		23d. LOCATION (City, town or county) (State) St. Michaels Md.		24. FUNERAL DIRECTOR'S SIGNATURE Munna C. Newman	
25a. REC'D BY REGISTRAR DATE FEB 20 '62				25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE	

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